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## SEX, SEXUAL PLEASURE, AND REPRODUCTION: HEALTH INSURERS DON'T WANT YOU TO DO THOSE NASTY THINGS

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"Simply put, having sexual relations is not a medical necessity."<sup>1</sup>

"The omnipresent process of sex, as it is woven into the whole texture of our man's or woman's body, is the pattern of all the process of our life."<sup>2</sup>

"[Sex:] The most fun I've ever had without laughing."<sup>3</sup>

### I. INTRODUCTION

Recently, Kaiser Permanente (Kaiser), the nation's largest HMO, and Aetna U.S. Healthcare (Aetna) announced that they would not cover a new drug, Viagra, for treatment of erectile dysfunction under their standard health insurance policies. The companies cited cost, demand, and potential for abuse as reasons. Most alarmingly, however, the insurers reasoned that a drug to treat the ability to have sex-

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1. *Aetna Refuses Coverage for Impotence Drug*, BEST'S INS. NEWS, June 16, 1998, at 1 (quoting Aetna U.S. Healthcare letter to New York Insurance Department conveying its decision to deny Viagra claims).

2. JOHN BARTLETT'S FAMILIAR QUOTATIONS, 578 (Justin Kaplan ed., 16<sup>th</sup> ed. 1992) (quoting Havelock Ellis (1859-1939), THE NEW SPIRIT).

3. JOHN BARTLETT'S FAMILIAR QUOTATIONS, 767 (Justin Kaplan, ed., 16<sup>th</sup> ed. 1992) (quoting Woody Allen, in ANNIE HALL (1997)).

ual intercourse was not a medical necessity, but rather a "quality of life" drug and its use a "recreational" or "lifestyle" decision.<sup>4</sup>

Health insurers and managed care providers<sup>5</sup> have long resisted covering matters of sexual and reproductive health. Their decisions make little sense and are not consistent with the expectations of insureds.

This article examines health insurer attitudes toward sexual health, satisfaction, and reproduction by focusing on insurance coverage for treatment of erectile dysfunction (impotency), gender dysphoria (transsexuality), pregnancy, infertility, contraception, and abortion. The issue of whether to cover treatment for these conditions has long perplexed insurers; the resulting decisions have disappointed consumers.<sup>6</sup> Insurers often focus on the specific medical condition, the precise treatment sought, and the exact language of the insurance contract to determine coverage. Unfortunately, in looking at the "trees" of contract clauses and treatment modalities to answer whether a claim is covered, insurers have failed to see the "forest." Asking broader questions would yield better reasoned policy. Is treatment of sexual and reproductive health medically necessary? Should sexual and reproductive health be covered under a health insurance contract?<sup>7</sup> From a public policy or economic viewpoint, it is difficult to justify why insurers generally cover treatment for some sexual matters, while declining coverage for others.<sup>8</sup>

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4. See Letter from Sal J. Uglietta, President, U.S. Healthcare, Inc., Regional Manager, Northeast Region, Aetna U.S. Healthcare, to Frederic L. Bodner, Assistant Deputy Superintendent and Chief, Health Bureau, State of New York Insurance Department (June 12, 1998) [hereinafter Aetna Letter] (on file with author); Kaiser Permanente Press Release 1 (June 19, 1998) [hereinafter Kaiser Press Release] (on file with author). Kaiser distinguished "between quality-of-life treatments and those deemed medically necessary." *Id.*

5. Collectively referred to as "insurers" unless specifically distinguished in the text.

6. While I sometimes use "condition," not all of the matters discussed herein are medical conditions. In particular, contraception and sterilization prevents the condition of pregnancy, and assisted reproductive technologies such as *in vitro* fertilization do not "treat" the underlying disease processes causing infertility.

7. See RICHARD POSNER, *SEX AND REASON* 111 (1992) (presenting an economic theory of sexuality and explaining that the "ends that sex serves" as "procreative, hedonistic, and sociable."). Judge Posner explains that sex is "volitional human behavior," but sexual desire "is rooted in our biological nature." *Id.* at 3.

8. See UNEVEN AND UNEQUAL/INSURANCE COVERAGE AND REPRODUCTIVE HEALTH SERVICES 5-8 (Alan Guttmacher Institute ed. 1994) [hereinafter UNEVEN & UNEQUAL]; RACHEL BENSON GOLD & CORY L. RICHARDS, *IMPROVING THE FIT/REPRODUCTIVE HEALTH SERVICES IN MANAGED CARE SETTINGS* 12 (1996) ("As would be expected, given the long-standing tradition of health insurance to cover surgical procedures, surgical reproductive health care services are well covered in typical insurance policies"); James Trussell, et al., *The Economic Value of Contraception: A Comparison of 15 Methods*, 85 AM. J. PUB. HEALTH 494, 502 (1995) (reporting results of economic study concluding that covering contraception is cost-effective for insurers and public health providers); Sally Roberts, *Plans More Likely to Cover Abortions Than Contraceptives*, 28 BUS. INS., Mar. 1994, at 7, 7.

Section II of this article discusses the "medicalization" of sex and the negative socio-medical attitudes toward sexual activity. This section also explores how such negativity has infected the insurance contract and why insurers traditionally have not covered matters of sexual and reproductive health. It concludes with a brief discussion of the bases on which insurers typically deny claims, including a brief look at Medicaid and state mandates.

Sections III and IV identify and discuss insurance coverage implications for six matters of sexual health. Section III examines treatment coverage issues for two matters related to sexual satisfaction: erectile dysfunction and gender dysphoria. Section IV examines reproductive health issues: pregnancy, infertility, contraception (reversible and nonreversible), and abortion.

Section V discusses the implications of continued refusal to cover matters of sexual and reproductive health, and the state and federal responses to denial of coverage. Insurers are waging a war against coverage of sexually-related medical conditions based on antiquated notions, resulting in the failure to deliver the basic sexual and reproductive health coverage insureds expect. By ignoring the fundamental expectations of consumers, insurers have made themselves vulnerable to legislatively written insurance contracts. However, because of the moral and political nature of sexuality, legislation is not a particularly appealing method of achieving a better insurance contract. For example, women's health may be compromised by legislative restrictions on reproductive health care choices. Neither insurers nor insureds should want Congress to write our insurance contracts. Instead, I argue that it is time for insurers to recognize our sexual nature and to voluntarily provide rational reproductive and sexual health care to the same extent insurers cover other common, less politically-charged medical conditions.

Insurers fear that providing coverage for sexual and reproductive health will result in excessive claims because sexual and reproductive activity is largely voluntary, its treatment expensive and desirable, and its demand among insureds very high. However, abundant external controls exist to curb the various moral hazard risks associated with sexual and reproductive health coverage. Insurers focus on the moral hazards of coverage, but fail to recognize that providing basic sexual and reproductive health care coverage makes good sense.<sup>9</sup>

## II. THE MEDICALIZATION OF SEX AND INSURANCE COVERAGE

The issue of whether health insurance should cover sexual matters takes place in the context of a much larger debate over the alloca-

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9. See generally Trussell, *supra* note 8, at 501-02.

tion and rationing of health care.<sup>10</sup> Two separate questions emerge to drive the coverage debate: 1) is sex medically necessary?; and 2) is sexual health a sufficiently high health priority to merit insurance coverage? The following sections examine two impediments to insurance coverage: the cloak of moral repugnance and the concept of moral hazard.

#### A. *Sex As Misconduct*

While matters concerning sexual health, pleasure, and function have never been the sole domain of medicine, medicine and science have assumed an increasingly prominent role in our sexual life.<sup>11</sup> Biological science, psychology, and medicine increasingly dominate our modern understanding of sexuality.<sup>12</sup> However, before there were scientific answers to explain sexuality, sexual pleasure, and procreation,

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10. See, e.g., Norman Daniels & James E. Sabin, *Last Chance Therapies and Managed Care*, 28 HASTINGS CTR. REP. 27 (1998); Baruch Brody, *Public Goods and Fair Prices: Balancing Technological Innovation with Social Well-Being*, 26 HASTINGS CTR. REP. 5 (1996); Sana Loue, *An Epidemiological Framework for the Formulation of Health Insurance Policy*, 14 J. LEGAL MED. 523 (1993); Clark C. Havighurst, *Prospective Self-Denial: Can Consumers Contract Today to Accept Health Care Rationing Tomorrow?* 140 U. PA. L. REV. 1755 (1992); Daniel Callahan, *Transforming Mortality: Technology and the Allocation of Resources*, 65 S. CAL. L. REV. 205 (1991); Norman Daniels, Comment, *Technology and Resource Allocation: Old Problems in New Clothes*, 65 S. CAL. L. REV. 225 (1991); Richard A. Rettig, *Artificial Kidneys and Artificial Hearts*, 65 S. CAL. L. REV. 503 (1991); Paul E. Kalb, M.D., *Controlling Health Care Costs by Controlling Technology: A Private Contractual Approach*, 99 YALE L.J. 1109 (1990).

11. See generally VERN L. BULLOUGH, *SCIENCE IN THE BEDROOM/A HISTORY OF SEX RESEARCH* 9-34 (1994) [hereinafter *BEDROOM*] (tracing the history of sex research from Greeks to the Nineteenth Century and noting the emerging role of physicians); RAYMOND A. BELLOTTI, *GOOD SEX: PERSPECTIVES ON SEXUAL ETHICS* 13-109 (1993) (tracing western view of sexuality); *DISCOURSES OF SEXUALITY/FROM ARISTOTLE TO AIDS* (Donna C. Stanton ed., 1992) [hereinafter *DISCOURSES*]; POSNER, *supra* note 7, at 85-111; Leonore Tiefer, *The Medicalization of Sexuality: Conceptual, Normative, and Professional Issues*, 7 ANNALS OF SEX RES. 252, 252-53 (1996).

In the provocative and ground-breaking *The History of Sexuality*, philosopher Michel Foucault writes of the modern western medicalization of sexuality:

[T]he sexual domain was no longer accounted for simply by the notions of error or sin, excess or transgression, but was placed under the rule of the normal and the pathological . . . ; a characteristic of sexual morbidity was defined for the first time; sex appeared as an extremely unstable pathological field: a surface of repercussion for other ailments, but also the focus of specific nosography, that of instincts, tendencies, images, pleasure, and conduct. This implied furthermore that sex would derive its meaning and its necessity from medical interventions: it would be required by the doctor, necessary for diagnosis, and effective by nature in the cure. Spoken in the time, to the proper party, and by the person who was both the bearer of it and the one responsible for it, the truth healed.

MICHEL FOUCAULT, *THE HISTORY OF SEXUALITY: AN INTRODUCTION* 67 (1978).

12. See *BEDROOM*, *supra* note 11, at 273. Sexology is a complex, multidisciplinary study involving, among others, the fields of medicine, biology, sociology, history, anthropology, psychology, and the humanities, while the twentieth century has been marked by medical dominance, which is changing. See *id.*; POSNER, *supra* note 7, at 13.

there were "observations, mythology, morals, and magic."<sup>13</sup> Now, however, the answers to our sexual and reproductive problems rest largely with medicine, pharmacology, surgery, and technology.

Although medical science has assumed more prominence in defining sexual normality and malady,<sup>14</sup> morality and moral judgment also continue to influence sexual behavior.<sup>15</sup> The Judeo-Christian tradition has long disapproved of nonprocreative sexual activity,<sup>16</sup> and at times medical science has joined with religion to dissuade the populace from engaging in nonprocreative sex.<sup>17</sup> Various seventeenth and eighteenth century medical theories, for example, warned that sexual activity sapped strength and vitality and caused illness, disease, mental decline, decay, and death.<sup>18</sup> In the nineteenth century, medical hostility toward nonprocreative sex led medical practitioners to caution against sexual pleasure and nonprocreative sex:<sup>19</sup>

Though it could not be denied that the male received pleasure in doing his duty to beget children, couples were warned about seeking or prolonging pleasures. This was because, among other things, there were "undeniable instances where children begotten in the moment of intoxication remained stupid and idiots during their whole life."

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Women especially had to be careful not to enjoy sex, because they were maternal, rather than sexual creatures. Only the diseased female had an "excessive animal passion."<sup>20</sup>

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13. See BEDROOM, *supra* note 11, at 2. "Masters and Johnson offered whole new areas for the gynecologist, urologist and other medical specialists to extend their services." *Id.* at 196. Posner notes, "[T]he Greeks did not *moralize* sex; the idea that sexuality is a moral category is invention, not discovery. Neither did they medicalize or psychologize sex; that was left for the Victorians to do." POSNER, *supra* note 7, at 24.

14. "Sexual life during the 20th century was ripe for medicalization because of important social changes affecting sexuality, on the one hand, and people's dearth of resources and skills for understanding sexuality on the other." Tiefer, *supra* note 11, at 272.

15. See BEDROOM, *supra* note 11, at 2. There remains a strong moral component to judgments concerning sexual activity. Consider the condemnation by some of homosexuality and the view that AIDS is "a judgment from God," or "nature's revenge." See Jeffrey Weeks, *Values in an Age of Uncertainty*, in DISCOURSES, *supra* note 11, at 389.

16. See BEDROOM, *supra* note 11, at 2-3. "In fact, it was the knowledge of sex that constituted the original sin that occurred in the Garden of Eden. Augustine, who set Christian doctrine on this, held that the sin of Adam and Eve is transmitted from parents to children through the sexual act, which, by virtue of lust that accompanies it, is inherently sinful." *Id.* at 3. See POSNER, *supra* note 7, at 45-50.

17. See BEDROOM, *supra* note 11, at 18-33.

18. See *id.* at 19-20.

19. See *id.* Writing about sex research in the 19th century in America, Bullough states, "In the United States, medical practitioners, most of whom thought of themselves as Christians, saw as part of their duty the education of the public to realize that God had designed 'intercourse of the sexes' for the production of offspring and for no other reason." *Id.* at 25.

20. *Id.* at 25 (footnotes and citations omitted). Nineteenth century physicians believed mental illness and sexual activity were linked. *Id.* "Sexuality . . . became for

In the nineteenth century, "the system makers were attempting to use scientific knowledge to preserve the status quo of traditional attitudes toward not only sexual issues but sex or gender roles as well."<sup>21</sup>

Medical negativity toward sexual activity continued into the early part of the twentieth century, where the study of sex was dominated by concern for the various venereal diseases promoted by prostitution and promiscuity.<sup>22</sup> The continued disapproval of nonprocreative sex led to doomed governmental policies to prevent venereal disease through abstinence, rather than by providing prophylactics.<sup>23</sup> The aim of medicine and government in this period was strengthening American resolve against nonprocreative sexual activity and not conceding our sexual nature.

Medicine and psychiatry have come to define our notions of what is normal and deviant, normal and inadequate, and normal and hyper.<sup>24</sup> That medicine is a partner in our sexual activity is indisputable.<sup>25</sup> We seek medical attention for care related to pregnancy, infertility, abortion, contraception, and sterilization. In addition, medicine defines and treats both the physical and psychological aspects of sexual dysfunction, inadequacy, gender identity, and dysphoria. Although medicine is a partner in the sexual health of Americans, medicine nevertheless remains, at best, ambivalent about sexual activity.<sup>26</sup> Even today, physicians often endorse sexual abstinence over sex-

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Freud the indispensable 'organic foundation' for a scientific explanation of mental disease." *Id.* at 87 (quoting FRANK J. SULLOWAY, FREUD, BIOLOGIST OF THE MIND: BEYOND THE PSYCHOANALYTIC LEGEND 98 (1979)).

21. BEDROOM, *supra* note 11, at 27. See also Vern Bullough, *History and the Understanding of Human Sexuality*, ANNALS OF SEX RES. 75, 82 (1990).

22. See BEDROOM, *supra* note 11, at 92-100.

23. See *id.* at 107 (describing, for example, failure of World War I policy to promote abstinence among soldiers as method to reduce venereal disease).

24. See *id.* at 203-05, 281. Psychiatry plays a key role in defining sexual pathology. The Diagnostic and Statistical Manual (DSM-IV) of the American Psychiatric Association removed transsexualism as a distinct diagnosis in 1994, in favor of a broader category of "Gender Identity Disorder" to acknowledge relative degrees and to acknowledge that not all transsexuals suffer emotional confusion and distress. See GIANNA E. ISRAEL & DONALD E. TARVER II, M.D., TRANSGENDER CARE: RECOMMENDED GUIDELINES, PRACTICAL INFORMATION, & PERSONAL ACCOUNTS 24-25 (1997) [hereinafter TRANSGENDER CARE]; Friedemann Pfäfflin, *Revision of the Harry Benjamin Standards of Care in Progress*, in GENDER BLENDING, 337 (Bonnie Bullough, et al. eds., 1997) [hereinafter GENDER BLENDING]. The Diagnostic and Statistical Manual of Mental Disorders ("DSM-III-R") eliminated Ego-dystonic homosexuality as a diagnosis. In a carefully worded statement, the association noted that the classification had "suggested to some that homosexuality itself was considered a disorder." DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 426 (3<sup>rd</sup> ed. rev. 1987).

25. See BEDROOM, *supra* note 11, at 273.

26. See BEDROOM, *supra* note 11, at 286-87 (describing how in the post 1960s era there was a decline in scientific research about human sexuality). The AIDS epidemic renewed interest in federal funding for study of human sexuality. See *id.* at 288-89. Moreover, early on in the AIDS crisis organized groups of sex researchers advocated abstinence as the panacea to AIDS, again revealing disapproval of nonprocreative sex. See *id.* Indeed, we are still reminded that we need not act sexually even if we are

ual activity,<sup>27</sup> despite the fact that sex is an “‘essentially important and pleasurable thing.’”<sup>28</sup>

B. *Moral Hazard and the Tradition of Excluding Coverage for the Treatment of Sexual and Reproductive Health Matters*

This section examines the concept of moral hazard as a source of insurer reluctance to cover sexual matters. Early health policies excluded almost all treatment of sexual and reproductive health matters on the grounds that coverage of these risks was unusual and that the voluntariness of sexual activity made insurers vulnerable to excessive claims. Although there has been some improvement, insurers continue to view sexual and reproductive health coverage as moral hazards for which insurance is inappropriate.

Despite the increasing medicalization of sex, health insurers have long balked at providing health coverage for sexual matters. Insurers have been reluctant to acknowledge that insureds are sexually active and require medical care to preserve their sexual health.<sup>29</sup> For example, the 1948 Statement of Principles for Personal Accident and Health Insurance articulated by the National Association of Insurance Commissioners admonished that “[n]o accident or sickness insurance contract should be issued unless it provides protection against sub-

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sexual. See Samuel A. Marcossou, *The “Special Rights” Canard in the Debate Over Lesbian and Gay Civil Rights*, 9 NOTRE DAME J.L. ETHICS & PUB. POL’Y 137, 179-80 & n.127 (1995) (criticizing current thought holding that even if homosexual orientation is “immutable,” sexual activity is a choice which should be deferred throughout lifetime).

27. For example, those guiding national health policy still preach against sex outside of marriage. See Louis W. Sullivan, *The Doctor’s Rx for America’s Troubled Children . . . Strengthen the American Family*, 2 KAN. J.L. & PUB. POL’Y 5, 9 (1992). In 1992, Dr. Louis Sullivan, while Secretary of Health and Human Services, discussed the department’s goal to strengthen traditional American values including reserving sex until marriage, and wrote, “We have seen very promising results from sex education using the abstinence approach.” *Id.* Disapproval of nonprocreative, nonmarital sex continues. See Amy L. Hansen, *Establishing Uniformity in HIV-Fear Cases: A Modification of the Distinct Event Approach*, 29 VAL. U. L. REV. 1251, 1254 & n.14 (1995) (describing government’s initial \$1.5 million “America Responds to AIDS” campaign in which the word “condom” or “sex” could not be mentioned, now replaced by multiple messages encouraging both condom use and abstinence).

28. Jeffrey G. Sherman, *Love Speech: The Social Utility of Pornography*, 47 STAN. L. REV. 661, 667 & n.60 (1995) (quoting Kristine Gebbie, President Clinton’s AIDS policy coordinator, and describing political aftermath of her remark in the context of confronting teen sexuality).

29. A Canadian study reports, “[Twenty-two percent of the] total dollar value of physicians’ services and hospital care used [by females was for] care associated with conditions specific to women [and three percent of the] total value of physicians’ and hospital care [for males] was associated with conditions specific to men.” Cameron Mustard, et al., *Sex Differences in the Use of Health Care Services*, 338 NEW ENG. J. MED. 1678, 1680 (1998). The development of a satisfactory pharmacological treatment of erectile dysfunction will likely increase the male health cost figure. See David R. Olmos, *Kaiser, Citing Cost, Won’t Pay for Viagra*, L.A. TIMES, June 20, 1998, at A1 (estimating that if covered, the drug will cost the plan \$100 million).

stantial hazards."<sup>30</sup> However, the Statement advocated a hands-off, narrow view rather than advocating broad coverage for sexual health:

Because of the unusual hazard not contemplated by the normal premium charge, other examples of proper exclusions are diseases contracted during or while in military (land, sea or air) service, minimum and maximum age limits, and *venereal disease*. For the same reason policies of sickness insurance designed for issuance to female risks *may properly exclude loss due to pregnancy, childbirth or miscarriage or to disease or derangement of the female generative organs*.<sup>31</sup>

Ironically, even for a policy insuring substantial hazards, sexual activity and its outcomes were regarded as "unusual." "It used to be common for insurers to except from the policy coverage diseases of 'organs not common to both sexes.'"<sup>32</sup> Policies therefore excluded coverage for prostatitis (an inflammation of the prostate),<sup>33</sup> fibroid tumors of the uterus,<sup>34</sup> and gonorrhea attacking the genitalia.<sup>35</sup> Policies commonly specifically excluded coverage for venereal disease as well.<sup>36</sup> Some policies excluded diseases peculiar to female organs in particular.<sup>37</sup> Despite the fact that every insured has a sexual identity and was conceived through a sexual act or a reproductive technology, insurers continued to find many of the risks associated with sexual organs outside the "usual hazards" of insurance. Even though approximately half of the population is female, female reproductive health was often specifically targeted and, even today, continues to be viewed as outside the common health insurance risks.<sup>38</sup>

Because sexual activity is viewed as largely voluntary, negative, and controllable conduct, insurers have long viewed coverage of sexual health aspects particular moral hazards to be avoided.<sup>39</sup> Under-

30. ACCIDENT AND SICKNESS INSURANCE (David McCahan ed. 1954) 331 app. G.

31. *Id.* at 315 (emphasis added).

32. JOHN A. APPLEMAN & JEAN APPLEMAN, INSURANCE LAW AND PRACTICE § 379 (1981).

33. *See id.* (citing *Bartalotte v. Commercial Cas. Ins. Co.*, 163 N.Y.S. 95 (1917)).

34. *See id.* (citing *Crisman v. Fidelity Health & Acc. Mut. Ins. Co.*, 95 N.E.2d 776 (Ohio Ct. App. 1950)).

35. *See id.* (citing *Hamilton v. Mutual Benefit Health & Acc. Ass'n*, 275 N.W. 863 (Neb. 1937)).

36. *See id.* (citing *Coleman v. National Life & Acc. Ins. Co.*, 145 So. 298 (La. Ct. App. 1933); *American Life & Acc. Ins. Co. v. Nirdlinger*, 73 So. 875 (Miss. 1917)).

37. *See id.* (citing *American Health Ins. Corp. v. Newcomb*, 91 S.E.2d 447 (Va. 1956)).

38. *See UNEVEN & UNEQUAL*, *supra* note 8, at 8-12; J. Henry Smith, *Meeting Surgical and Medical Expense*, in ACCIDENT AND SICKNESS INSURANCE, *supra* note 30, at 76, 78.

39. Moral hazard exists when the possession of an insurance policy increases the likelihood of incurring a covered loss, and/or the size of the covered loss. In health care, moral hazard implies that people use more services when they are insured, or more fully insured. *See* Thomas Rice, *Can Markets Give Us the Health System We Want?*, 22 J. HEALTH POLITICS POL'Y & L. 383, 412 (1997). *See generally* Tom Baker, *On the Genealogy of Moral Hazard*, 75 TEX. L. REV. 237 (1996) (tracing history and evolution of moral hazard in insurance).



writers earlier cautioned of the excessive risks and the moral hazard of insuring the sexually active:

The most important aspect of moral hazard as a factor in health insurance underwriting is the probable adverse effect on the attitude of the individual towards contracts and his integrity and good faith in his dealings with the insurer. Engaging in criminal activities, gambling, association with criminal or underworld elements, *improper standards of sexual conduct* and engaging in illegal occupations not only involve extra risk to health and life, but also must be assumed to result in excessive claim costs arising from lack of integrity in dealing with an insurance company.<sup>40</sup>

Several aspects of moral hazard arise in considering sexuality and insurance. Insurers try to avoid insuring persons whose character makes them vulnerable to the temptation of insurance.<sup>41</sup> Older policies excluding venereal diseases demonstrate the bad character/coverage aspect of moral hazard.<sup>42</sup> The aversion persists today as Aetna reasoned that consumers might mix Viagra and "poppers" or amyl nitrate, and that this conduct is evidence of the "performance enhancement/lifestyle nature of Viagra."<sup>43</sup> One senses that the sex-crazed sinner of yesteryear still threatens insurers and dissuades them from covering people engaging in sexual activity. Thus, the roots of sexual health exclusions remain partly grounded in the stigma and disapproval associated with sexual activity.<sup>44</sup>

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Economists view moral hazard not as a concept of "morality" but of minimizing "incentive" to benefit from insurance. See *id.* at 270-71. Nevertheless, insurers continue to view the avoidance of moral hazard as avoiding insureds with bad character and avoiding the creation of moral hazards through insurance incentives. See *id.* See Marnie Mueller, *Financing High-Tech Reproductive Medical Expenditures*, 6 STAN. L. & POL'Y REV. 113, 115-16 (1995) (discussing moral hazard and adverse selection in assisted reproductive technology coverage).

40. EDWIN L. BARTLESON, ET AL., HEALTH INSURANCE: PROVIDED THROUGH INDIVIDUAL POLICIES 58 (1963) (emphasis added).

41. Thus, the above passage, alluding to those engaging in sexual misconduct as a heightened insurance risk, reflects moral hazard's concern for character. See Baker, *supra* note 39, at 250 (referring to "people . . . whose character suggested that they were unusually susceptible to the temptation that insurance can create"). "To the nineteenth-century pantheon of incendiaries, swindlers, itinerants, and the heedless, twentieth-century insurance writers added delinquents, malingerers, hypochondriacs, people with bad credit, and those who pursue 'aspirational,' rather than 'medically necessary,' therapy." *Id.* at 266 (footnotes omitted).

42. For nineteenth-century insurers, "moral hazard" represented an unwholesome mix of bad character and temptation which the insurers had a responsibility to ferret out from the insurance enterprise. The concept's significance lay not in recognition that insurance could have undesirable consequences . . . but instead in the claim that the undesirable consequences could be controlled.

Baker, *supra* note 39, at 240 (footnotes omitted) (also describing the contemporary view of moral hazard in insurance).

43. See Aetna Letter, *supra* note 4, at 6-7.

44. Consider Aetna's portrayal of sex-hungry old men seeking enhanced performance with younger women:

Insurers may also try to avoid creating an incentive that lures even people of "good character" to engage in covered risks for financial gain through insurance claims. Therefore, insurers may avoid over-insuring risks so that insureds will not have an incentive to create a payoff for themselves. In health care, insurers try not to encourage overuse of medical services brought about by the existence of insurance coverage.<sup>45</sup> The moral hazard of overuse may explain insurer reluctance to cover sexual matters such as assisted reproductive technologies. Insurers fear that desperate infertile couples might overutilize assisted reproductive technologies despite low success rates simply because an insurer is paying the cost.<sup>46</sup> Similarly, insurers have expressed the concern that the existence of insurance coverage will cause inappropriate and excessive use of Viagra.<sup>47</sup>

Insurers avoid insuring matters which lie within the control of the insureds so as not to tempt insureds to create claims.<sup>48</sup> In matters of sexual and reproductive health, the ability of the insured to control

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Reports on the explosion of Viagra prescriptions . . . indicate that it is being used primarily to boost sexual performance and is not medically necessary . . . .

Evidence abounds. Dr. Steven Lamm, an internist in Manhattan, took time away from examining a 52 year-old man who wanted Viagra as "insurance" in his relationship with a 24 year-old woman. "His goal was repeated orgasms, though he also inquired about a drug to deal with his baldness . . . . I can't make these things up." Dr. Lamm also contended that Viagra is tapping a new market; "the vast majority of men who have asked about the drug have never gone to the doctor and asked about their [alleged] dysfunction . . . . What you're seeing is a monumental landmark in the field of sexual medicine. This is not repair work anymore. I'm a coach now."

Aetna Letter, *supra* note 4, at 2.

45. Discussing the work of Kenneth Arrow, Baker explains the concept as applied to health insurance:

Arrow addressed the "moral hazard" of insurance, which he explicitly defined as "the effect of insurance on incentives." Arrow described that effect as occurring when "the event against which insurance is taken out" lies "in the control of the individual" who benefits from the insurance. As Arrow explained, individuals may have little control over illness, but they do have control over which doctor to use, and they may base that decision upon a doctor's willingness to use more costly medical services. In the presence of health insurance, this control leads to two potential moral hazard effects: increased utilization of medical services and increased prices for those services.

Baker, *supra* note 39, at 267-68 (quoting Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 944 (1963)).

46. See Mueller, *supra* note 39, at 114. "Moral hazard is a real potential concern in the choice of which reproductive techniques to use. If cost is no constraint, the infertile couple will want to use the most advanced technology available, even if it is low yield." *Id.* at 114. This statement ignores the disincentives inherent in seeking medical care such as discomfort, pain, fear, loss of privacy, and consumption of time.

47. See Aetna Letter, *supra* note 4, at 5-7. Aetna warns of two types of overuse, first by men seeking to unnaturally enhance an already healthy sexual ability and by "heavy usage." See *id.* at 6-7. "People with erectile dysfunction will use it to have sex five times a night." *Id.* at 7 (quoting UCLA urologist Stanley Korenman).

48. See RICHARD A. EPSTEIN, FORBIDDEN GROUNDS/THE CASE AGAINST EMPLOYMENT DISCRIMINATION LAWS 335 (1992) [hereinafter FORBIDDEN GROUNDS]

the occurrence of the insured risk raises a concern that insureds will engage in the behavior<sup>49</sup> that causes the covered risk.<sup>50</sup> For example, insurers reason that, "[b]ecause pregnancy is desired, and because women largely control whether and when to become pregnant, the evident moral hazard makes pregnancy a poor candidate for any form of insurance."<sup>51</sup>

Insurers are probably over-inflating the significance of moral hazard in sexual and reproductive health coverage. It is unlikely that the existence of insurance is a primary motivation to make certain sexual and reproductive choices. Many other external considerations, such as the life-altering consequences of these decisions, the physical and psychological toll of treatment, as well as the physician's gate-keeper role, keep demand for health services in check.<sup>52</sup>

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("[W]omen are more likely to choose to become pregnant if they can receive disability payments for an outcome they regard as beneficial").

49. The rationale of good and bad behavior is entangled in the avoidance of insuring volitional behavior. "Insurance cannot soundly cover deliberate acts of the insured, so suicide and self-inflicted injuries are excluded. For the same reasons, benefits for pregnancy and childbirth are usually quite limited or may be excluded entirely." O.D. DICKERSON, *HEALTH INSURANCE* 217 (1968).

50. See Richard A. Epstein, *Rationing Access to Medical Care: Some Sober Second Thoughts*, 3 *STAN. L. & POL'Y REV.* 81, 86 (1991). See also *Fuller v. CBT Corp.*, 905 F.2d 1055, 1057 (7th Cir. 1990) (upholding plan's refusal to cover cost of reversing vasectomy); *Connecticut Gen. Life Ins. Co. v. Shelton*, 611 S.W.2d 928, 932 (Tex. Ct. App. 1981) (refusing to cover reversal of tubal ligation and noting moral hazard of voluntary, elective event).

51. *FORBIDDEN GROUNDS*, *supra* note 48, at 329. See also Olmos, *supra* 29, at A1 ("Why should all Kaiser members have to foot the bill so some people can have more frequent sex?").

52. The physical, psychological and uncompensated economic costs (such as time away from work) associated with undergoing unnecessary medical procedures may help curb overutilization. For example, the concern that women will overutilize maternity benefits ignores other, stronger reasons both to have and not have children: The answer is that parents do not make child care (or pregnancy) decisions on a purely economic basis. If they did consider economics seriously, most adults, of course, would forego parenting altogether. See Ruth Colker, *Pregnancy, Parenting, and Capitalism*, 58 *OHIO ST. L.J.* 61, 68-69 (1997); Samuel Issacharoff & Elyse Rosenblum, *Women and the Workplace: Accommodating the Demands of Pregnancy*, 94 *COLUM. L. REV.* 2154, 2216 & n.288 (1994) ("Given the minimal level of support through the 12 weeks of pregnancy leave, the massive costs associated with childrearing in general, and the entire complex of welfare subsidies already available to women with young children, it is unlikely that the proposed pregnancy leave benefits will induce significantly altered behavior."); Lucinda M. Finley, *Choice and Freedom: Elusive Issues in the Search for Gender Justice*, 96 *YALE L.J.* 914, 929 (1987) (reviewing DAVID L. KIRP ET AL., *GENDER JUSTICE* (1986) (disagreeing that voluntariness of pregnancy is a ground for policy of denying insurance coverage)). Similarly, one can hardly imagine overutilization of sex-reassignment surgery, both in light of the rigorous standards and the radical nature of treatment. See discussion *infra* Part III.B.

As to abortion choices, research indicates that funding plays little role in decisionmaking. See discussion *infra* Part IV.C. Likewise, although others suggest that infertility treatment at the high-tech end may increase with increased coverage, extracting eggs and hormone treatments seem sufficiently uncomfortable procedures to prevent overutilization. See *infra* note 366. Finally, because health care utilization is

A "patchwork"<sup>53</sup> of coverage and exclusions reflecting vestiges of a Victorian view of sexuality have replaced early health insurance contracts that excluded almost all matters related to sexual activity. While coverage for treatment of pregnancy<sup>54</sup> and venereal disease<sup>55</sup> have improved over the last few decades, new issues of coverage for sexual and reproductive health have emerged such as coverage for contraception,<sup>56</sup> infertility and assisted reproductive technologies,<sup>57</sup> gender dysphoria,<sup>58</sup> and sexual dysfunctions.<sup>59</sup>

Although consumer demand for sexual and reproductive health care is high,<sup>60</sup> insurers continue to view sexual activity in a negative light. Aetna, for example, condemned Viagra as a "love drug" or "passion pill," with the potential to be demanded by a teenager "[who]

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desirable while overutilization is not, insurers should develop more precise external controls (such as utilization review) to prevent overutilization rather than exclusions. See Baker, *supra* note 39, at 281; CLARK C. HAVIGHURST, HEALTH CARE CHOICES 137-40 (1995) [hereinafter CHOICES]; Peter J. Neumann, *Should Health Insurance Cover IVF? Issues and Options*, 22 J. HEALTH POLITICS POL'Y & L. 1215, 1227 (1997).

Even the demand for Viagra should be self-limiting as it purportedly does not enhance sexual performance in normally functioning males (and no one questions the insurers' right to limit quantity). See discussion *infra* Part III.A. On the other hand, Aetna contends without any basis that even the potential lethality of Viagra will not curb its abuse, quoting a urologist stating, "I know a whole lot of men who would say, 'If I go out in the saddle, that's all right with me, but I want to be riding.'" Aetna Letter, *supra* note 4, at 8 (quoting Dr. Ira Sharlip (member of impotence guidelines committee of the American Urological Association)).

53. See UNEVEN & UNEQUAL, *supra* note 8, at 25 (urging transformation of "our current patchwork into a rational system that effectively finances and promotes good reproductive health care while addressing the needs and circumstances of women, men and their families."). The Segal Company reports 100% of HMO's and indemnity plans surveyed in 1998 "have some form of exclusion or limitation with respect to coverage for medication and services related to reproduction and sexual dysfunction." SEGAL COMPANY, SURVEY OF HEALTH PLAN EXCLUSIONS FOR MEDICATION AND SERVICES RELATED TO REPRODUCTION AND SEXUAL DYSFUNCTION (1998) (on file with author) [hereinafter SEGAL COMPANY].

54. See discussion *infra* Part IV.A.

55. Most insurers now provide coverage for the diagnosis and treatment of sexually transmitted diseases; however, issues of coverage for routine health screening, including screening for sexually transmitted diseases remains. See UNEVEN & UNEQUAL, *supra* note 8, at 8.

56. See discussion *infra* Part IV.B.

57. See discussion *infra* Part IV.D.

58. See discussion *infra* Part III.B.

59. See discussion *infra* Part III.A.

60. A recent study by the Kaiser Family Foundation found 75% of "Americans believe that insurers should be required to pay for the full range of prescription birth control products . . . . [T]he number of Americans who believe Viagra should be covered hovers just below 50 percent." *Should Insurers Cover Contraception? Americans Say Yes*, MED. UTILIZATION MGMT., June 25, 1998, available in 1998 WL 10321886 [hereinafter *Contraception*]. Another study found that Americans were willing to pay higher taxes (an average willingness of \$32) in order to provide in vitro fertilization services to infertile couples. See Neumann, *supra* note 52, at 1224-25 (citing Peter J. Neumann & Magnus Johannesson, *The Willingness to Pay for In Vitro Fertilization: A Pilot Study Using Contingent Valuation*, 32 MED. CARE 686-99 (1994)).

want[s] Viagra 'just to have it in his pocket' on a Saturday night."<sup>61</sup> Although men and women regularly engage in sexual activity, insurers continue to believe that the treatment of sexual matters are "unusual hazard[s] not contemplated by the normal premium charge."<sup>62</sup> Importantly, although insurance may not motivate sexual and reproductive conduct, when procedures are unaffordable, the absence of coverage impacts access to health care.<sup>63</sup>

Women suffer disproportionately when insurers do not cover matters concerning sex and reproduction.<sup>64</sup> During their childbearing years, women spend substantially more on health care, and have less insurance, or have less favorable insurance coverage for their health needs than men.<sup>65</sup> Women use thirty percent more health care resources than men, and the difference is principally related to sex-specific conditions during the childbearing years.<sup>66</sup> Thus, when insurers neglect coverage for sexual and reproductive health matters generally,<sup>67</sup> insurers negatively impact women disproportionately.<sup>68</sup>

The disparity is substantial: studies indicate that women's out-of-pocket health care expenses are approximately sixty-eight percent more than men, largely due to poor insurance coverage for matters of

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61. Aetna Letter, *supra* note 4, at 3.

62. ACCIDENT AND SICKNESS INSURANCE, *supra* note 30, at app. G.

63. See Kalb, *supra* note 10, at 115 (footnotes omitted) ("[T]he rate at which that technology is utilized depends almost entirely upon whether it is covered by insurance.").

64. See UNEVEN & UNEQUAL, *supra* note 8 *passim*. See also *Contraception*, *supra* note 60; *House Panel Approves Insurance Coverage for Contraceptives*, ASSOCIATED PRESS POL. SERV., June 19, 1998, available in 1998 WL 7424352; Deborah Barfield, *Debate Swirls on Care Equity/ Focus in Congress on Contraceptive Payments*, NEWSDAY, June 28, 1998, at A26; *Snowe Announces Senate Hearing to Address Inequities Between Men & Women in Prescription Coverage*, GOV'T PRESS RELEASE, July 1, 1998, available in 1998 WL 7325045.

65. See Susan L. Waysdorf, *Fighting For Their Lives: Women, Poverty, and the Historical Role of United States Law in Shaping Access to Women's Health Care*, 84 KY. L.J. 745, 757 (1996).

66. See Mustard, *supra* note 29, at 1681-82; Jennifer Haas, *The Cost of Being a Woman*, 338 NEW ENG. J. MED. 1694, 1694 (1998); Gene Emery, *Except for Childbearing Years, Women's Health Care Costs Equal Men's*, CHI. TRIB., July 5, 1998, at 8.

67. "[M]ost women in the United States rely on some form of health insurance to help them defray some of their medical expenses. According to a recent study conducted by the Women's Research and Education Institute, 67% of women of reproductive age rely on private, employment-related coverage, obtained through either their own employer or a family member's employer." UNEVEN & UNEQUAL, *supra* note 8, at 4 (citing Women's Research and Education Institute, *Women's Health Insurance Costs and Experience*, (Washington D.C. 1994)).

68. See Haas, *supra* note 66, at 1694. Women's sexual and reproductive health needs are covered less frequently than men's. See *id.* A recent survey indicates 93% of insurers do not cover infertility treatment and 59% do not cover oral contraception. See SEGAL COMPANY, *supra* note 53. On the other hand, only 15% do not cover treatment of impotency, including Viagra, and vasectomies. See *id.*

sexual and reproductive health.<sup>69</sup> However, rather than offer more coverage to women to correct this disparity, Aetna, in convoluted fashion, recently justified excluding Viagra coverage under the rationale that two wrongs do make a right. Aetna cloaked its argument in the constitutional equality of the sexes and the right of privacy:

The American College of Obstetricians and Gynecologists and Planned Parenthood have criticized some plans for covering Viagra for men, but not paying for women's birth control, because these plans assist men in engaging in sexual activity, but not women.

Under the penumbra of the Right of Privacy, the right in question is the right to procreate. *This logically leads to the position that an insurer need not cover Viagra because procreation, like contraception, is not a medical necessity.*

Thus, Aetna U.S. Healthcare is taking a logical and consistent approach to coverage of Viagra and contraceptives: Contraceptives are available through an endorsement to the Prescription Plan Rider, and our recently filed endorsement treats Viagra and similar drugs in the same fashion.<sup>70</sup>

Aetna's position is indeed logical and consistent: neither men nor women should expect coverage for matters of sexual and reproductive health.<sup>71</sup>

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69. See Sylvia Law, *Sex Discrimination and Insurance for Contraception*, 73 WASH. L. REV. 363, 374 (1998) (quoting Women's Research and Education Institute, *Women's Health Insurance Costs and Experiences* 2 (1994)).

70. Aetna Letter, *supra* note 4, at 8.

71. Although insurers characterize sexual activity and reproductive choices as not medically necessary or as lifestyle choices, recently, the United States Supreme court held that under the Americans with Disabilities Act, "Reproduction falls within the phrase 'major life activity.' Reproduction and the sexual dynamics surrounding it are central to the life process itself." *Bragdon v. Abbott*, \_\_ U.S. \_\_, 118 S.Ct. 2196, 2205 (1998). Now that the court has announced that reproduction falls squarely within the ADA, the insurance coverage landscape may need to change. The ADA prohibits discrimination by employers providing fringe benefits, even if those fringe benefits are not administered by the employer. See 29 C.F.R. § 1630.4(f) (1990). Disability-based distinctions in health insurance are permissible when the employer can show the distinction is based on "'underwriting risks, classifying risks, or administering such risks that are not inconsistent with State law,' and that is not being used as a 'subterfuge' to evade the purposes of the ADA." 2 EEOC Compl. Man. (BNA) No. 176, at N:2301, N:2302-03 (June 8, 1993). The EEOC position is that employers must demonstrate that any disability-based distinction (such as non-coverage for specific medical conditions) is not a subterfuge, by showing, for example, that it is "justified by legitimate actuarial data, or by actual or reasonably anticipated experience, and that conditions with comparable actuarial data and/or experience are treated in the same fashion." *Id.* at N:2306. Reproductive and sexual health matters may no longer be excluded merely because they are of relative low priority. See generally D'Andra Millsap, *Sex, Lies, and Health Insurance: Employer-Provided Health Insurance Coverage of Abortion and Infertility Services and the ADA*, 22 AM. J.L. & MED. 51 (1996) (arguing that under ADA and EEOC guidelines employers should not be able to exclude coverage for infertility and abortion).

### C. *The Coverage Game*

#### 1. How Insurers Deny Coverage

Insurers generally employ three methods to decline insurance coverage for certain procedures or for treatment of particular health matters.<sup>72</sup> One method is to limit coverage to “medically necessary” treatment and to determine that a particular treatment is not “medically necessary” under the insurance policy.<sup>73</sup> Clauses defining “medically necessary” vary; however, these clauses generally require that treatment be medically “appropriate” with some reference to customs and standards in the community or within that medical specialty.<sup>74</sup> “Medically necessary” does not usually connote a more narrow concept such as “essential,” although some courts have interpreted it as such.<sup>75</sup> More often, “[m]edical necessity” is not intended to mean

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72. See Frank P. James, *The Experimental Treatment Exclusion Clause: A Tool for Silent Rationing of Health Care?*, 12 J. LEGAL MED. 359, 359-67 (1991) (describing explicit and implicit forms of insurer health care rationing).

73. See CHOICES, *supra* note 52, at 125-132 (medical necessity as the “touchstone” of insurance obligation); Mark A. Hall & Gerald F. Anderson, *Models of Rationing: Health Insurers’ Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1645-47 (1992); Norman Daniels, *Technology and Resource Allocation: Old Problems in New Clothes*, 65 S. CAL. L. REV. 225, 235 (1991). See generally John A. Glenn, Annotation, *What Services, Equipment, or Supplies are “Medically Necessary” for Purposes of Coverage Under Medical Insurance*, 75 A.L.R.4th 763 (1990 & Supp. 1997).

74. For example, in *Schneider v. Wisconsin UFCW Unions & Employers Health Plan*, 985 F. Supp. 848, 850 (E.D. Wis. 1997) the plan provided that:

“necessary or medically necessary” means only those services, treatments, or supplies . . . that are required in the judgment of the Trustees to identify or treat a Person’s illness or injury and which are:

- (a) consistent with the symptoms or diagnosis and treatment of the Persons [sic] condition, disease, ailment, or injury;
- (b) appropriate according to the standards of good medical practice;
- (c) not solely for the convenience of the Person, Physician, or Hospital; and
- (d) the most appropriate which can be safely provided to the person.

See also *McGraw v. Prudential Ins. Co.*, 137 F.3d 1253, 1256 (10th Cir. 1998) (defining necessity as a service or supply that must be ordered by a doctor, recognized in the doctor’s profession as safe and effective, is required for diagnosis or treatment, is employed appropriately in manner and setting consistent with generally accepted medical standards and is not educational, experimental nor investigational); *Alcorn v. Sterling Chemicals Inc. Med. Benefits Plan for Hourly-Paid Employees*, 991 F. Supp. 609, 614 (S.D. Tex. 1998) (defining medically necessary “in terms of generally accepted medical standards”); *Mann v. Prudential Ins. Co. of Am.*, 790 F. Supp. 1145, 1149 (S.D. Fla. 1992) (defining medically necessary: “[t]o be ‘needed’ a service must be (a) ordered by a doctor, (b) commonly and customarily recognized throughout the doctors’ profession as appropriate in the treatment or diagnosis of the sickness or injury, (c) neither educational nor experimental in nature . . . , and (d) neither furnished mainly for the purpose of medical nor other research”).

75. See *Kinzie v. Physician’s Liab. Ins. Co.*, 750 P.2d 1140, 1141 (Okla. 1987) (interpreting medically necessary as “essential” and finding *in vitro* is not essential); *Lockshin v. Blue Cross of N.E. Ohio*, 434 N.E.2d 754, 756 (Ohio App. 1980) (interpreting medically necessary as “required,” “compulsory,” “essential,” “indispensable,” or “unavoidable,” and holding private nurse was not necessary). Compare with *Aberna-*

life-or-death necessity, but merely medically appropriate or medically beneficial."<sup>76</sup> Generally, the insurer plays a key role in determining or establishing the process by which medical necessity is determined, and the physician's order alone does not establish necessity for coverage purposes.<sup>77</sup>

When a policy contains no exclusions, courts typically, but not uniformly, view the treatment of sexual diseases or dysfunction as medically necessary.<sup>78</sup> Nevertheless, insurers persistently argue with some success that treatment of sexual and reproductive disorders is elective, cosmetic,<sup>79</sup> or unnecessary.<sup>80</sup> Aetna's and Kaiser's contention that sexual relations are not medically necessary but involve a quality of life choice<sup>81</sup> is a predictable insurers' position.

A second method of declining coverage is to determine whether the proposed treatment is experimental under a standard exclusion of coverage for experimental treatments.<sup>82</sup> In theory, the experimental-treatment exclusion serves both cost and public policy interests.<sup>83</sup> After all, individual insureds are not well-served when subjected to unproven and potentially worthless treatments, and insurance consumers are generally harmed by paying higher premiums to cover unproven treatments.<sup>84</sup> The battle ground in these disputes is whether a treatment has moved beyond the experimental label toward medical community acceptance.<sup>85</sup>

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thy v. Prudential Ins. Co. of Am., 264 S.E.2d 836, 837-38 (S.C. 1980) ("medically necessary" as "appropriate" and covering depilatory treatment to remove excess facial hair). See also CHOICES, *supra* note 52, at 128 (noting a few plans employ the term "essential").

76. Hall & Anderson, *supra* note 73, at 1646 n.27 (citing *Dallis v. Aetna Life Ins. Co.*, 574 F. Supp. 547 (N.D. Ga. 1983)).

77. The early policies provided no such limitation and generally covered all care ordered by a physician. See Hall & Anderson, *supra* note 73, at 1644-45. Questionable or excessive demands for coverage and judicial deference to physician orders prompted insurers to insert the clause. See *id.* See also CHOICES, *supra* note 52, at 130-31.

78. See, e.g., *Doe v. Northwestern*, 355 S.E.2d 867 (S.C. 1987) (covering cost of penile prosthesis to treat symptoms of diabetic-caused impotency); *Davidson v. Aetna Life & Casualty Ins. Co.*, 420 N.Y.S.2d 450 (1979) (holding sex-change is not cosmetic surgery).

79. See *Robertson v. NN. Investors Life Ins. Co.*, 385 S.E.2d 681, 681 (Ga. Ct. App. 1989) (penile implant constituted cosmetic surgery); *Davidson*, 420 N.Y.S.2d at 451 (sex-change is cosmetic surgery).

80. See *Kinzie v. Physician's Liab. Ins. Co.*, 750 P.2d 1140, 1141 (Okla. 1987) (in vitro fertilization will not "cure" the disease of infertility).

81. See Aetna Letter, *supra* note 4, at 3. See also Kaiser Press Release, *supra* note 4, at 1.

82. See CHOICES, *supra* note 52, at 132; Hall & Anderson, *supra* note 73, at 1640 & n.13 (gathering articles on the experimental treatment clause exclusion); James, *supra* note 72, at 366; Kalb, *supra* note 10, at 1111.

83. See Hall & Anderson, *supra* note 73, at 1677-81; Kalb, *supra* note 10, at 1112.

84. See James, *supra* note 72, at 386 (citing *Elser v. I.A.M. Nat'l Pension Fund*, 684 F.2d 648 (9th Cir. 1982)).

85. See James, *supra* note 72, at 377-85.



The insurance contract often defines experimental<sup>86</sup> as being accepted in the medical community and having been subjected to evaluation by some form of clinical review.<sup>87</sup> Assisted reproductive technologies and sex-reassignment surgery are typically attacked as experimental by insurers, while insureds argue they are standard treatments.<sup>88</sup> In the pharmaceutical arena, once drugs are approved by the Food and Drug Administration (FDA) for particular indications, the drugs are not regarded as experimental for that use; however, insurers may still deny coverage for "off-label" uses.<sup>89</sup>

A third method insurers use to decline coverage is to specifically exclude coverage for particular diseases or treatments.<sup>90</sup> Most notably, express exclusions or limited coverages exist for cosmetic surgery, preexisting conditions, and mental illness;<sup>91</sup> many other specific procedures, treatments, or diseases are excluded in policies as well. Exclusions often seem random; "one senses that their listing may reflect some past controversy in which the plan found itself embroiled and that coverage of many of these services could be denied by another plan under more general language."<sup>92</sup>

Employing express exclusions poses multiple problems. First, express exclusions are "clumsy rationing tools in the same way that meat axes are inferior to scalpels in doing surgery. Some highly beneficial services in the excluded categories are inevitably excised from coverage, while some very questionable services continue to be financed because contract language is not precise enough to exclude them."<sup>93</sup> In addition, express exclusions cannot keep pace with new medical developments; therefore insurers may find it difficult to draft clauses that exclude coverage as broadly as they desire.<sup>94</sup> Moreover, exclusion clauses are plagued by judicial inconsistencies that afford little cer-

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86. See *id.* at 367 (citing an example of how insurance carrier derived its definition of radial ketatotomy).

87. See Hall & Anderson, *supra* note 73, at 1654. See, e.g., *Stringfield v. Prudential Ins. Co. of Am.*, 732 F. Supp. 69 (E.D. Tenn. 1989); *Lehman v. Mutual of Omaha Ins. Co.*, 806 F. Supp. 859 (D. Ariz. 1992).

88. See *infra* Part IV and *supra* Part III.B.

89. An "off-label use of a prescription drug is a use not included in the FDA approved indications." See Drusilla S. Raiford, et al., *Determining Appropriate Reimbursement for Prescription Drugs: Off Label Uses and Investigational Therapies*, 49 FOOD & DRUG L.J. 37, at 38 (1994); Aetna Letter, *supra* note 4, at 9.

90. See Hall & Anderson, *supra* note 73, at 1684; CHOICES *supra* note 52, at 141; Havighurst, *supra* note 10, at 1774.

91. See Brian D. Shannon, *Paving the Path to Parity in Health Insurance Coverage for Mental Illness: New Law or Merely Good Intentions?*, 68 U. COLO. L. REV. 63, 70-73 (1997); Youndy C. Cook, Comment, *Messing with Our Minds: The Mental Illness Limitation in Health Insurance*, 50 MIAMI L. REV. 345, 346-47 (1996).

92. CHOICES, *supra* note 52, at 141.

93. Havighurst, *supra* note 10, at 1774. See also Hall & Anderson, *supra* note 73, at 1684 (noting difficulty of drafting clauses with precision and free of ambiguity).

94. See Mark A. Hall, et al., *Judicial Protection of Managed Care Consumers: An Empirical Study of Insurance Coverage Disputes*, 26 SETON HALL L. REV. 1055, 1063 & n.12 (1996).

tainty to insurers attempting to use exclusions to fix their costs and risks.<sup>95</sup>

Insurers sometimes justify exclusions on the grounds that certain diseases and treatments involve "diagnostic ambiguity," "elastic interventions," or "vague end points."<sup>96</sup> When the diagnosis or treatment is vague and subjective, insurers fear that they will have no means by which to check excessive utilization.<sup>97</sup> Plans denying coverage for Viagra recently cited these reasons, complaining the diagnosis of impotency was too subjective and that mass-marketing artificially increased consumer demand for the drug.<sup>98</sup>

Insurers also justify exclusions on the grounds that the procedures are too expensive in comparison to success or medical necessity. For example, sex-reassignment surgery is viewed as too costly in light of its perceived purpose; in vitro fertilization is viewed as too costly in light of its poor success rate; and reversal of voluntary sterilization is not medically necessary in light of its voluntariness.<sup>99</sup>

## 2. Medicaid Coverage Determinations

Government-funded programs pay a substantial portion of health care bills.<sup>100</sup> While Medicaid methods of making determinations regarding coverage is similar to private plans, its methods are not identical. Medicaid<sup>101</sup> is a cooperative<sup>102</sup> state and federal program which

95. See Hall & Anderson, *supra* note 73, at 1684 (citing Lee N. Newcomer, *Defining Experimental Therapy—A Third Party Payer's Dilemma*, 323 NEW ENG. J. MED. 1702 (1990)).

96. Cook, *supra* note 91, at 346 & n.6 (citing Barry Blackwell, *No Margin, No Mission*, 271 JAMA 1466 (1994)); Shannon, *supra* note 91, at 69-70. See also Aetna Letter, *supra* note 4, at 3-5 (complaining that diagnosis is too difficult, especially fueled by the manufacturer feeding excessive fears of normal males).

97. See Cook, *supra* note 91, at 346. Physicians can play an important role as a gatekeeper. See Mark A. Hall, *Rationing Health Care at the Bedside*, 69 N.Y.U. L. REV. 693, 703-05 (1994) (discussing potential role of physician in health care rationing decisions); Hall & Anderson, *supra* note 73, at 1666-68 (discussing limitations on effectiveness of the physician as gatekeeper); Baker, *supra* note 39, at 267-69 (discussing physician's role in utilization in context of moral hazard).

98. See Aetna Letter, *supra* note 4, at 3-5; Kaiser Press Release, *supra* note 4, at 1 (identifying the issue that mass marketing raises demand).

99. See CHOICES, *supra* note 52, at 141 & n.19 (referring to these as "items of low priority (both as health needs and candidates for insurance coverage) compared with covered services").

100. Insurers pay approximately 30% of health care costs, the federal and state governments (insurance for the aged, disabled and indigent) pay approximately 40% and individuals, charities and self-insured corporations pay approximately 30%. See Kalb, *supra* note 10, at 1111 (citing DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH UNITED STATES 160 (1988)).

101. See Title XIX of the Social Security Act, 42 U.S.C. § 1396u (1994).

102. Medicaid is an example of "cooperative federalism" in which gives the states latitude to design and implement a program using federal funds and guidelines. See Lisa B. Deutsch, *Medicaid Payment for Organ Transplants: The Extent of Mandated Coverage*, 30 COLUM. J.L. & SOC. PROBS. 185, 187; C. David Flower, Note, *State Discretion in Funding Organ Transplants Under the Medicaid Program: Interpretive Guidelines in Determin-*

provides medical assistance to indigent and disabled persons.<sup>103</sup> Although voluntary, if a state chooses to participate in the Medicaid program, it must comply with federal statutory and regulatory mandates.<sup>104</sup> Although not an insurance contract, coverage issues under Medicaid are similar in that a state may limit health care coverage to those procedures that are "medically necessary"<sup>105</sup> and not "experimental" or "medically inappropriate."<sup>106</sup> While a state has discretion in establishing and designing its Medicaid program, including coverage, a state "may not arbitrarily deny or reduce the amount, duration, or scope of a required service . . . to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition."<sup>107</sup> Moreover, while a state may place "appropriate limits" on services,<sup>108</sup> the state must promulgate standards that are consistent with the objectives of the Medicaid Act.<sup>109</sup>

As to pharmaceuticals, state Medicaid programs generally must pay for any use of a "covered outpatient drug" that is either approved by the FDA or is generally accepted or appropriate.<sup>110</sup> The new debate as to whether states can elect not to cover Viagra marks a collision between concepts of "medically necessary" treatments and coverage for FDA-approved drugs prescribed by a physician.<sup>111</sup>

### 3. State and Federal Mandates: A Less Than Effective Means Around the Insurance Contract

In recent years, consumers have attempted to use the legislative process to sidestep coverage disagreements with insurers and to frus-

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*ing the Scope of Mandated Coverage*, 79 MINN. L. REV. 1233, 1236 & n.12 (1995); Anna Wermuth, Comment, *Kidcare and the Uninsured Child: Options for an Illinois Health Insurance*, 29 LOY. U. CHI. L.J. 465, 472 & n.60 (1998) (citing Colleen A. Foley, *The Doctor Will See You Now: Medicaid Managed Care and Indigent Children*, 21 SETON HALL LEGIS J. at 93-94 (1997)).

103. See Flower, *supra* note 102, at 1236.

104. See *Alexander v. Choate*, 469 U.S. 287, 289 & n.1 (1985); *Weaver v. Reagen*, 886 F.2d 194, 197 (8th Cir. 1989).

105. Flower, *supra* note 102, at 1241; Wermuth, *supra* note 102, at 474-83; Deutsch, *supra* note 102, at 187-89.

106. Deutsch, *supra* note 102, at 187-88.

107. 42 C.F.R. § 440.230(c) (1997).

108. See 42 C.F.R. § 440.230(d) (1997). See also 42 U.S.C. § 1396a(a)(17) (1994).

109. See *Beal v. Doe*, 432 U.S. 438, 443-45 (1977); *Weaver*, 886 F.2d at 198; Flower, *supra* note 102, at 1242; Maxwell J. Mehlman, *The Oregon Medicaid Program: Is it Just?*, 1 HEALTH MATRIX 175, 179-80 (1991). Recently, the Second Circuit discussed the breadth of the state's latitude in designing and limiting coverage and held that a state could set limits on coverage even though particular services were medically necessary for an individual. See *DeSario v. Thomas*, 139 F.3d 80, 92 (2d Cir. 1998), *petition for cert. filed*, \_\_\_ U.S. \_\_\_ (1998) (No. 98-5070). Broadly ruling for state flexibility, the Second Circuit stated, "There is no requirement that a state fund every medically necessary procedure or item falling within a service it covers under its plan." *Id.*

110. See Raiford, *supra* note 89, at 39 (citing Omnibus Budget Reconciliation Act of 1990, 42 U.S.C. § 1396a).

111. See *infra* note 173.

trate insurers relying on contract language to exclude consumer-desired treatments.<sup>112</sup> State mandates<sup>113</sup> for specific health care coverage are numerous.<sup>114</sup> Critics argue that insurance policies that are legislatively created through state mandates raise premiums, reduce consumer choice, disproportionately concentrate health care resources on particular health problems, and eventually increase the number of uninsured individuals.<sup>115</sup> The politically charged nature of sexual and reproductive choices makes matters of sexual and reproductive health ripe for legislative action to both broaden and limit coverage.<sup>116</sup> Thus, legislation regarding sexual and reproductive health may just as easily erode as protect sexual health.

The Employment Retirement Income Security Act (ERISA) governs and regulates employee welfare benefit plans established and maintained by employers or employee organizations.<sup>117</sup> ERISA's impact on health insurance cannot be underestimated because the majority of Americans are covered under ERISA plans.<sup>118</sup> ERISA contains a preemption clause which dilutes the ability of states to mandate specific insurance coverage insured under some ERISA plans.<sup>119</sup>

112. See Hall & Anderson, *supra* note 73, at 1684.

113. "State mandated benefits are laws that prescribe the terms of coverage for group insurance purchased from [Blue Cross/Blue Shield] and commercial insurers. Such laws include requirements that plans cover specific services, categories of providers, diseases, or persons who might otherwise have difficulty obtaining coverage." Gail A. Jensen, *State Insurance Regulation and Employers' Decisions to Self-Insure*, J. RISK & INS. 185, June 1, 1995, available in 1995 WL 12368804. Some mandates require only that insurers "offer" the option to purchase coverage. See Neumann, *supra* note 52, at 1218-20 (surveying states with mandates to cover or mandates to offer and impact); Melissa R. O'Rourke, *The Status of Infertility Treatments and Insurance Coverage: Some Hopes and Frustrations*, 37 S.D. L. REV. 343, 366 (1992); William C. Cole, *Infertility: A Survey of the Law and Analysis of the Need for Legislation Mandating Insurance Coverage*, 27 SAN. DIEGO L. REV. 715, 724 (1990); Christine A. McAteer, *Health Care Mandates: The Delivery Debate*, 26 SETON HALL L. REV. 1691, 1694-98 (1996) (discussing the merits of 48 hour minimum in-hospital care for mothers and newborns).

114. "Between 1980 and 1990, the number of state mandates (in place across all the states) almost doubled, from 450 to 854." Jensen, *supra* note 113, at 187 (citing MANDATED BENEFITS MANUAL (1992)).

115. See Note, *In Vitro Fertilization: Insurance and Consumer Protection*, 109 HARV. L. REV. 2092, 2099-2100 (1996) (describing the pros and cons of state mandates).

116. See *infra* notes 346-350 and accompanying text.

117. See 29 U.S.C. § 1002(1) (1994).

118. See Millsap, *supra* note 71, at 51, 54 n.26 (collecting reported statistics). The Health Insurance Association of America indicates that 32% of small employers, 85% of large employers (25 employees or more) offer health benefits, and 77% of employees work in firms making health benefits available. SOURCE BOOK OF HEALTH INSURANCE DATA 26 (Health Ins. Ass'n of Am. ed. 1992) [hereinafter SOURCE BOOK]; see also MARK V. PAULY, PH.D., HEALTH BENEFITS AT WORK 78-79 (1997) (noting increasing availability of employer-offered health insurance and that approximately 59% of workers take insurance coverage through their employment).

119. See 29 U.S.C. §§ 1001-1461 (1994).

The federal ERISA law expressly preempts state laws that conflict with the federal regulation of employee welfare benefit plans.<sup>120</sup> A savings clause within ERISA exempts state laws regulating insurance;<sup>121</sup> however, ERISA provides that an employee benefit plan is not deemed to be an insurance company or engaged in the business of insurance.<sup>122</sup> Therefore, employers who “self-fund” or “self-insure” their employee welfare benefit plans may escape the obligation insurers have to comply with state insurance mandates.<sup>123</sup> Thus, the more onerous state mandates become, the more attractive self-insuring health plans become to employers who are able to self-insure.<sup>124</sup> As self-funded plans increase, state mandates will affect fewer health plans.

While free from state mandates, self-insured employee welfare benefit plans and other ERISA plans do not escape the requirements of federal mandates. Consequently, the mandates found in federal acts such as the Pregnancy Discrimination Act of 1978,<sup>125</sup> the Newborns’ and Mothers’ Health Protection Act of 1995,<sup>126</sup> and the Mental Health Parity Act of 1997<sup>127</sup> are applicable even to ERISA self-insured health plans.<sup>128</sup> Thus, despite state law’s traditional role in

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120. See 29 U.S.C. § 1144(a) (1994).

121. See 29 U.S.C. § 1144(b)(2)(A).

122. See 29 U.S.C. § 1144(b)(2)(B).

123. See Loue, *supra* note 10, at 535; see also Laura J. Schacht, Note, *The Health Care Crisis: Improving Access for Employees Covered by Self-Insured Health Plans Under ERISA and the Americans With Disabilities Act*, 45 WASH. U. J. URB. & CONTEMP. L. 303, 311 (1994); SOURCE BOOK, *supra* note 118, at 3-4. The self-insured fund also avoids certain state tax consequences and earns interest on its reserves, additional factors which make self-insuring attractive. See Mueller, *supra* note 39, at 119 n.12; see also Jensen, *supra* note 113; Cole, *supra* note 113, at 731-33.

124. See Schacht, *supra* note 123, at 305, 310-14 (64% of all employers self-insure). These self-insured plans often contract to purchase administrative services through commercial insurers. See *id.* at 311 n.30; see also Jensen, *supra* note 113, at 185 (noting that self-insuring employers in the 1980s, “became the leading underwriters of all group coverage in the United States, accounting for 58 percent of all group health premiums by the close of the decade”); Dwight McNeill, *Accountability Begins With You*, 15 BUS. & HEALTH 51, Dec. 1, 1997, available in 1997 WL 9588701; SOURCE BOOK, *supra* note 118, at 4 (noting growth of self-insurance).

125. See 42 U.S.C. § 2000e(k) (1994).

126. See 42 U.S.C. §§ 300gg-4, 300gg-41 (Supp. 1996); 29 U.S.C. § 1185 (Supp. 1996).

127. See 29 U.S.C. § 1185a (Supp. 1996); 42 U.S.C. § 300gg-5 (Supp. 1996).

128. See Diane West, *New Mandates, ERISA Butt Heads*, NAT’L UNDERWRITER PROF. & CAS./RISK & BENEFITS MGMT., May 1998, at 33.

regulating insurance,<sup>129</sup> new mandates will likely be proposed at the federal level in order to reach self-insured employee benefit plans.<sup>130</sup>

### III. SEXUAL SATISFACTION, PERFORMANCE, AND DYSFUNCTION

#### A. *Impotency*

##### 1. Viagra: A Magic Pill At Last

The prevalence of sexual dysfunction among American males is substantial,<sup>131</sup> but until recently, treatment options were few and unappealing.<sup>132</sup> In March 1998, the FDA approval of an important new drug, sildenafil,<sup>133</sup> for the treatment of erectile dysfunction raised new insurance issues concerning the medical necessity of treatment for sexual dysfunction generally.<sup>134</sup>

Erectile dysfunction, "the persistent inability to achieve or maintain an erection sufficient for satisfactory sexual performance, is esti-

129. The McCarran-Ferguson Act generally reserves to the states the regulation of the business of insurance. See 15 U.S.C. §§ 1011-1015 (1994). On the other hand, the Employee Income Retirement Security Act of 1974 (ERISA) preempts state law in the area of employee benefits. See 29 U.S.C. § 1144(a) (1974). The interplay of the two preemption statutes is "one of the knottiest problems of statutory interpretation imaginable." ROBERT H. JERRY, II, UNDERSTANDING INSURANCE LAW 75 (2d ed. 1996). In *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985), the Court held that an insurance company providing ERISA governed benefits was not exempt from a state mandate requiring mental health benefits to insureds; however, the Court noted that an uninsured or self-insured plan would enjoy preemption because these plans did not involve the business of insurance.

130. See proposed laws cited *infra* note 317.

131. In a study of men between the ages of 40 and 70, 52% reported minimal, moderate, or complete impotence. See Henry A. Feldman, et al., *Impotence and its Medical and Psychosocial Correlates: Results of the Massachusetts Male Aging Study*, 151 J. UROLOGY 54, 55 (1994). Although this section will focus principally on treatment for impotency, both men and women report a variety of sexual dysfunctions. In a 1978 study of well-educated, happily-married couples, with a median age of 35 for females and 37 for males, 40% of males reported erectile or ejaculatory dysfunction, and 63% of the women reported arousal or orgasmic dysfunction. See Ellen Frank, et al., *Frequency of Sexual Dysfunction in "Normal" Couples*, 299 NEW ENG. J. MED. 111, 111-15 (1978).

132. See *infra* notes 164-86.

133. According to Pfizer, Viagra (sildenafil citrate) is an oral therapy for erectile dysfunction. See Pfizer, *Viagra, The FDA Approved Impotence Pill*, (visited Oct. 18, 1998) <[http://www.viagra.com/hcp/prod\\_info\\_temp.html](http://www.viagra.com/hcp/prod_info_temp.html)>. "The physiologic mechanism of erection of the penis involves release of nitric oxide (NO) in the corpus cavernosum during sexual stimulation . . ." *Id.* Sildenafil "enhances the effect of nitric oxide . . ." *Id.* Pfizer reports that "[s]ildenafil at recommended doses has no effect in the absence of sexual stimulation." *Id.*

134. See generally Robert D. Utiger, *A Pill for Impotence*, 338 NEW ENG. J. MED. 1458, 1459 (May 14, 1998); IMPOTENCE: NATIONAL INSTITUTE OF HEALTH CONSENSUS STATEMENT ONLINE 1992 (Dec. 7-9, 1992) (visited Oct. 1, 1998) <<http://text.nlm.nih.cdc/www.nih.gov>> [hereinafter CONSENSUS]. The NIH Consensus Development Conference on Impotence recommended replacing the term impotence with "erectile dysfunction." See *id.*

mated to affect up to thirty million men in the United States."<sup>135</sup> In a national study, erectile dysfunction "accounted for 400,000 outpatient visits to physicians and 30,000 hospital admissions, resulting in total direct costs of \$146 million" before Viagra's approval.<sup>136</sup> Projected annual Viagra sales range from \$1 billion<sup>137</sup> to \$4.5 billion<sup>138</sup> to as much as \$8 billion.<sup>139</sup> Demand for Viagra prescriptions will likely result in a dramatic increase in doctor visits as well.<sup>140</sup> Aetna projected that the increased costs of covering Viagra and resulting higher insurance premiums could leave 400,000 to 800,000 more individuals uninsured.<sup>141</sup>

The causes of erectile dysfunction are multifactorial and broadly classified as organic or psychological.<sup>142</sup> Erectile dysfunction may be a symptom of many underlying diseases and conditions, including, among others, diabetes mellitus, endocrinological conditions, hypertension, vascular disease, alcoholism, and depression.<sup>143</sup> Even after accounting for illness, medication, and psychopathology, advanced age also contributes to diminished sexual performance. However, sexual activity typically continues into old age.<sup>144</sup> Total or partial erectile dysfunction affects fifty-seven percent of men over the age of seventy,

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135. Irwin Goldstein, et al., *Oral Sildenafil in the Treatment of Erectile Dysfunction*, 338 NEW ENG. J. MED. 1397, 1397 (1998); see also CONSENSUS, *supra* note 134, (10-20 million diagnosed with erectile dysfunction increases to 30 million when a category for partial dysfunction is added).

136. See Feldman, *supra* note 131, at 54 (citing NATIONAL CENTER FOR HEALTH STATISTICS: DETAILED DIAGNOSES AND PROCEDURES FOR PATIENTS DISCHARGED FROM SHORT-STAY HOSPITALS: UNITED STATES, 1985 (*Vital and Health Statistics*, series 13, No. 90, U.S. DEP'T. OF HEALTH AND HUMAN SERV. PUB. NO. PHS 87-1851 (1987))).

137. See Michelle Fay Cortez, *Fatalities Cast Shadows Over Sales of a Sex Drug*, J. REC. (Okla. City), May 27, 1998, available in 1998 WL 11954223. Kaiser estimated that "national coverage of the pill would cost at least \$100 million a year, even if users were limited to 10 pills a month." Larry D. Hatfield, *Kaiser Refuses to Cover Viagra*, S.F. EXAM'R, June 19, 1998, at A1.

138. See David Stipp & Robert Whitaker, *The Selling of Impotence*, FORTUNE, Mar. 16, 1998, at 115, 116; Aetna Letter, *supra* note 4, at 11 (estimating national sales of Viagra at \$5 billion and prescription coverage for its insureds at \$50 million (excluding other medical costs)).

139. See Geoffrey Cowley, *Is Sex A Necessity?*, NEWSWEEK, May 11, 1998, at 62 (assuming half of the estimated 30 million men affected take Viagra once a week).

140. See Aetna Letter, *supra* note 4, at 11.

141. See *id.*

142. See CONSENSUS, *supra* note 134.

143. Additional NIH risk factors include: high levels of blood cholesterol, low levels of high density lipoprotein, drug use, neurogenic disorders, Peyronie's disease, priapism, lack of sexual knowledge, poor technique, inadequate interpersonal relationships, chronic diseases including renal failure, and prior vascular surgery. Other risk factors may include advancing age and smoking. See CONSENSUS, *supra* note 134; see also Feldman, *supra* note 131, at 55-59.

144. See Raul C. Schiavi, *Sexuality and Aging in Men*, ANN. REV. OF SEX RES. 227, 244 (1990). Nevertheless, total or partial impotence ("the inability to achieve and maintain vaginal penetration until orgasm on at least 50% of the attempts during the preceding 6 months") remains a distinct dysfunction. *Id.* at 243.

in contrast to the seven percent of men between the ages of twenty and thirty.<sup>145</sup>

Viagra is the first effective oral therapy available for the treatment of erectile dysfunction,<sup>146</sup> although at least one other drug may soon be approved.<sup>147</sup> Prior to Viagra's much-heralded approval, other oral treatments were largely ineffective.<sup>148</sup> Alternative medicines of limited or questionable success have included herbal remedies<sup>149</sup> and symbolic remedies, such as rhinoceros horns and other natural objects shaped like the erect penis.<sup>150</sup> Oral hormones have also proven unsuccessful.<sup>151</sup> The quest for a cure has been relentless and ageless: "hundreds of bizarre remedies, from boar gall to tiger-penis soup, have won believers through the ages — desperate males are easily fooled by placebo effects which can temporarily ameliorate mild impotence. A century ago men even mail-ordered electrified jockstraps in hopes of jump-starting their inoperative parts."<sup>152</sup> Drug studies in the past decade reported small success following clinical trials with numerous other drugs.<sup>153</sup>

Similarly, non-oral therapies for erectile dysfunction have had limited success as treatment options;<sup>154</sup> for aesthetic or comfort reasons, many have not been well accepted by patients.<sup>155</sup> For example,

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145. *See id.* at 227, 244.

146. *See id.*

147. *See* Elizabeth Cosgrove, *Vasomax May Offer Impotent Men Alternative to Viagra*, CNN INTERACTIVE (visited Oct. 2, 1998) <<http://cnn.com/health/9806/02/viagra.alterative/index.html>>; Stipp & Whitaker, *supra* note 138, at 122 (not yet approved but in phase III trials and promising fewer side effects).

148. *See* Goldstein, *supra* note 135, at 1397 ("No effective oral therapy for erectile dysfunction is currently available").

149. These include ginseng, crushed fennel seeds, licorice, pollen, sarsaparilla, Asafoetida, hops, and small dried beetles (commonly known as the Spanish fly). *See* Waguih R. Guirguis, *Oral Treatment of Erectile Dysfunction: From Herbal Remedies to Designer Drugs*, 24 J. SEX & MARITAL THERAPY 69, 69-70 (1998). Their efficacy has never been established. *See id.*

150. *See id.* at 70 (noting the belief that the user's penis will become as "strong and as erect as the rhino's horn").

151. *See id.* (hormonal treatment is more likely to increase desire rather than ability, and thus is largely ineffective).

152. Stipp & Whitaker, *supra* note 138, at 115.

153. *See* Guirguis, *supra* note 149, at 70-71 (including yohimbine, trazodone, phenoxybenzamine, bromocriptine, oxytocin, glyceryl trinitrate, zinc, phentolamine, apomorphine, and naltrexone). "None of these recent drugs gave rise . . . to any real improvement over that claimed by proponents of herbal remedies." *Id.* at 71.

154. Treatments have included: vascular surgery, penile prostheses (implants), psychotherapy and behavioral therapy, androgen replacement therapy (when testicular failure is established), intracavernosal injection therapy (injection of vasodilator substances into the corpora of the penis), vacuum/constrictive devices (a vacuum device enlarges the penis and a constrictive device maintains the erection during intercourse). *See* CONSENSUS, *supra* note 134; *Medical Therapies for Erectile Dysfunction: What's Practical?*, CONTEMPORARY UROLOGY Dec. 1997, at 34, 38 [hereinafter *Medical Therapies*].

155. *See* CONSENSUS, *supra* note 134; *Medical Therapies*, *supra* note 154, at 38.



one of the more successful medical interventions prior to Viagra was injection of vasodilator substances directly into the penis.<sup>156</sup> Understandably, physical or emotional discomfort with injectables resulted in a high patient dropout rate.<sup>157</sup> Penile prosthetic devices have also had limited success.<sup>158</sup>

In short, until Viagra, treatment choices were so limited, unsuccessful, or unappealing<sup>159</sup> that insurance companies had few worries of excessive demand. Until now, there was no "magic pill."<sup>160</sup> Complicating matters, the definition of erectile dysfunction now includes a subjective satisfaction component and a category for mild dysfunction.<sup>161</sup> Viagra's side effects and complications are reportedly minor,<sup>162</sup> and combined with the medical recognition of partial erectile dysfunction, literally millions of men may now appropriately seek treatment for erectile dysfunction.<sup>163</sup>

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156. One particularly unpleasant side effect could be an unrelenting erection (priapism), which may require potentially life-threatening medical intervention in patients suffering from hypertension. See CONSENSUS, *supra* note 134; see also Stipp & Whitaker, *supra* note 138, at 116.

157. See CONSENSUS, *supra* note 134. The most common injectable, papaverine, could cause life-threatening complications. See *id.* Other treatments, each with limited success, include vacuum constriction devices, penile prostheses, and surgery. See *id.* See also *Medical Therapies*, *supra* note 154, at 38.

158. See CONSENSUS, *supra* note 134 ("Mechanical failure, infection, and erosions" have been the main problems, in addition to surgical risk and failure requiring reoperation); *Medical Therapies*, *supra* note 154, at 45 ("Penile implants are currently our most effective form of therapy in terms of long-term satisfaction, yet at the follow-up, only 70% of men are still using their devices.").

159. See *Medical Therapies*, *supra* note 154, at 45 (footnote omitted) (discussing difficulties of treatment (prior to FDA approval of Viagra)).

160. "Clinicians in this field often are told at the end of an assessment interview, 'I wish you had a magic pill' . . . Finding such a treatment has always been the dream of many scientists, and many attempts have been made over the years." Guirguis, *supra* note 149, at 69.

161. See CONSENSUS, *supra* note 134 (emphasis added) (referring to the "inability of the male to attain and maintain erection of the penis sufficient to permit *satisfactory* sexual intercourse").

162. See Goldstein, *supra* note 135, at 1403. "The American Urological Association Panel on the Treatment of Organic Erectile Dysfunction stated that the ultimate goal is a therapy that is reliable, has minimal side effects, and is simple to use. Sildenafil appears to meet these specifications." *Id.* (citations omitted). Like Phenylen, approval by the FDA and widespread availability may reveal previously unknown or underappreciated side effects. See *Sixteen Deaths Among Viagra Users Prompt Renewed Warning*, CNN INTERACTIVE (visited Oct. 18, 1998) <<http://cnn.com/health/9806/09/viagra/index.html>> (reporting Viagra deaths attributed to exertion and/or interaction with nitrate-containing heart drugs); Victoria Slind-Flor & Bob Van Voris, *Viagra May Have Legal Downside*, NAT'L L.J., May 18, 1998, at A1 (describing ophthalmologic effect); Stipp & Whitaker, *supra* note 138, at 120 ("The worst nightmare for developers of sex pills and other impotence therapies . . . is that the craze for ED pills will lead to a rash of 'coital coronaries.'").

163. See Feldman, *supra* note 131, at 55, 58 (describing Massachusetts Male Aging Study and statistical validity of subjective assessment of the existence of "minimal, moderate, or complete impotence"); Goldstein, *supra* note 135, at 1402 (describing

## 2. Insurance Coverage for Viagra

Recently, Aetna decided not to cover Viagra under its health plans unless employers purchased an optional rider. Aetna characterized Viagra as a "recreational/lifestyle" drug and expressed concern that "Viagra could cost it more than \$50 million a year."<sup>164</sup> Similarly, Kaiser, the nation's largest health maintenance organization, announced it would not cover pharmaceuticals for treatment of sexual dysfunction in future plans, but would make an optional supplemental benefit rider available to large purchasers.<sup>165</sup> Revealing an internal inconsistency, Kaiser acknowledged that sexual dysfunction remained a covered illness, and that it would continue to provide medical care to evaluate sexual dysfunction. However, it deemed coverage of pharmaceuticals a "distinction between quality-of-life and [treatment] deemed medically necessary."<sup>166</sup>

Both the subjectivity of the diagnosis and the comparative ease of the new treatment<sup>167</sup> concern insurers considering Viagra coverage<sup>168</sup> and dosage limitations<sup>169</sup> under existing drug plans.<sup>170</sup> While Kaiser and Aetna deny coverage for the drug unless a special rider is

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self-administered International Index of Erectile Function). See also Stupp & Whitaker, *supra* note 138, at 118 (describing the new "epidemic"); David Morrow, *Insurers Limiting Payments for Use of Impotence Pill*, N.Y. TIMES, Apr. 29, 1998, at A4 (reporting that large insurers are "fearing huge payouts to millions of American men"); Ovetta Wiggins, *State Limits Viagra Coverage Four Pills a Month for Workers, Seniors*, RECORD (N. N.J.), June 5, 1998, at A1 (state's bill under its state employee and Medicaid plans for Viagra totaled \$483,000 for April, 1998 and fears that without limits state's Viagra bill may reach \$6 million a year).

164. *Drugs: Aetna Won't Pay for Viagra in N.Y.*, L.A. TIMES, June 17, 1998, at D4 [hereinafter *Drugs*].

165. See Kaiser Press Release, *supra* note 4, at 1.

166. *Id.* Kaiser will reportedly not cover pharmaceutical treatments. See Olmos, *supra* note 29, at A1.

167. Users are instructed to take a tablet by mouth "approximately 1 hour before sexual activity" but that it is effective anywhere from one-half to four hours prior to sexual activity. Pfizer, *supra* note 133.

168. See John Hendren, *Health Care Premiums to Spiral*, J. REC. (Okla. City), June 3, 1998, available in 1998 WL 11954372 (attributing rising costs of insurance to "lifestyle drugs" such as Viagra); David R. Olmos, *Insurers Hold Reins with Viagra: Drug Brings Big Role the Health Industry Plays to Forefront*, DET. NEWS, June 7, 1998, at A5 [hereinafter *Insurers Hold Reins*]; *Prudential Sued Over Viagra Non-Coverage*, REC. (N. N.J.), May 29, 1998, at B2 (reporting on lawsuit filed for denial of coverage); Slind-Flor & Van Voris, *supra* note 162, at A1 ("insurance companies and insurance lawyers are asking themselves how much is enough, as the companies decide whether-and how often-to reimburse patients using Viagra"); *Business World: Suing for Viagra*, J. REC. (Okla. City), May 19, 1998, available in 1998 WL 11953991 (reporting lawsuit filed against Oxford Health Plans).

169. Pfizer states that the "maximum recommended dosing frequency is once per day." Pfizer, *supra* note 133 (Dosage and Administration). When covered, insurers are limiting the monthly allocation. See, e.g., Maura Lerner, *Health Insurers Balk at Paying \$10 a Piece for Viagra Pills*, STAR-TRIB. (Minneapolis-St.Paul), June 3, 1998, at A1 (reporting on Minnesota's three largest health plans' decisions to study before covering); *Insurers Hold Reins*, *supra* note 168; Wiggins, *supra* note 163 (reporting that New

purchased, other insurers are establishing clinical guidelines to discourage inappropriate prescriptions.<sup>171</sup> Likewise, states are struggling to decide how to provide Medicaid<sup>172</sup> coverage for Viagra in light of the federal command to cover it.<sup>173</sup>

Characterizing Viagra as a "lifestyle" drug places it squarely within the moral hazards insurers have typically avoided.<sup>174</sup> However, without a specific exclusion for the treatment of impotency or Viagra in particular, it is difficult to conclude that a prescription for the treatment of impotency is not medically necessary.<sup>175</sup> How can Kaiser rec-

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Jersey's Blue Cross and Blue Shield will pay for 12 pills per month while Cigna Healthcare of Northern New Jersey limits patients to six pills).

170. See Olmos, *supra* note 29, at A1 (quoting Dr. Francis J. Crosson, executive director of the Permanente Foundation) (commenting that the panel it assembled to develop Kaiser's policy "was unable to find a scientific or clinical basis for determining who should get Viagra and who should not"). Only 15% of plans reportedly exclude coverage for Viagra and impotency. See SEGAL COMPANY, *supra* note 53.

171. See Eileen Glanton, *Nation's Largest HMO Won't Cover Viagra*, CHARLESTON GAZETTE, June 20, 1998, at 7A, available in 1998 WL 5958203 (Blue Cross/Blue Shield of Rochester is covering six pills per month for patients who have suffered impotency for at least six months).

172. Medicaid generally requires coverage for use of any FDA approved drugs that are deemed medically necessary. See Raiford, *supra* note 89, at 38-39. See also Laurie McGinley, *U.S. Considering Requiring Medicaid to Pay for Viagra*, WALL ST. J., May 29, 1998, at B6 (reporting that federal officials doubt that Viagra will fall into an exempted Medicaid coverage category); Hilary Waldman, *State Limits Medicaid Viagra Payments*, HARTFORD-COURANT, May 30, 1998, at B2 (reporting on federal policy requiring state Medicaid programs to pay for any FDA approved drugs and commenting, "The policy has irked some men with private insurance companies, many of which refuse to pay for Viagra").

173. See Michele Boorstein, *Two States Refuse to Pay for Viagra*, AUSTIN AM. STATESMAN, July 4, 1998, at A6 (reporting that New York and Wisconsin plan to deny coverage in defiance of directive and Michigan is considering its options); *Voinovich Asks U.S. to Review Medicaid Ruling on Viagra*, PLAIN DEALER (Cleveland, Ohio), July 13, 1998, at 4B (Ohio balking, estimating cost at \$12.6 million per year); Jerry Zremski, *State to Ignore Order to Pay for Viagra*, BUFFALO NEWS, July 4, 1998, at A1. In response, the House Appropriations Committee is now considering bills to allow states to refuse Viagra coverage and to prohibit federal expenditures for Viagra. See *House Panel Oks Labor-HHS Bill, Sets Stage For Fight*, CONGRESS DAILY/A.M., July 15, 1998, available in 1998 WL 12689683. The variability of coverage among Medicaid programs and between Medicaid and private insurers has drawn comment on the inequities. See Avram Goldstein, *Medicaid Covers Viagra in Maryland and D.C., Not in Virginia*, WASH. POST, May 9, 1998, at A1; Debra Saunders, *Government in the Bedroom: Viagra Nation*, S.F. CHRON., May 22, 1998, at A25 (reporting that Medicaid programs in Alabama and Florida have a four-pill cap, Louisiana and Maryland cap at six pills, Utah at 10 and California has no cap and has approved at least one prescription for 30 pills).

174. When Kaiser announced its decision, Kaiser reportedly assembled a national group of Kaiser physicians, pharmacists, ethicists and health policy experts, who, reportedly considered the large costs as well as "the distinction between quality-of-life treatments and those deemed medically necessary." Kaiser Press Release, *supra* note 4, at 1.

175. For example, although each provider is permitted latitude, many Blue Cross/Blue Shield plans define medical necessity as:

- 1) required for diagnosis or treatment of an illness or injury;

ognize the diagnosis of impotency as a medical condition for which it continues to provide coverage, but characterize its treatment as a quality-of-life issue for which it will not provide coverage? Kaiser has acknowledged that demand and cost are prime factors, thus suggesting that the extraordinary success and subsequent demand for a treatment justifies excluding coverage.<sup>176</sup> While insurers probably are correct that Viagra promises to be a "blockbuster" pharmaceutical,<sup>177</sup> which may contribute to escalating health costs and premiums if abused and overprescribed,<sup>178</sup> Aetna and Kaiser have maligned the disease of impotency and characterized its treatment as a "lifestyle" choice,<sup>179</sup> harkening back to the concept of moral hazard.<sup>180</sup>

Rather than refusing coverage, insurers could have developed external controls to curb abuse. Insurers covering Viagra could require doctors to firmly establish the diagnosis to exclude inappropriate uses.<sup>181</sup> Possible coverage solutions include setting limits on coverage when the cause is not organic (in plans that exclude or limit coverage for psychiatric ailments),<sup>182</sup> when erectile dysfunction is caused by al-

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2) consistent with the symptoms or diagnosis and treatment of the illness or injury;

3) appropriate with regard to standards of good medical practice;

4) not primarily for the convenience of patient and provider.

Raiford, *supra* note 89, at 51.

176. See Kaiser Press Release, *supra* note 4, at 1.

177. See Cowley, *supra* note 139, at 62 ("even a \$1 billion drug is considered a blockbuster — but a big burden for a health-care system").

178. See Diane Levick, *Insurers Cracking Down on Medicines/Prescription Use Soars; HMOs Fight Rising Cost*, HARTFORD COURANT, June 7, 1998, at A1 (reporting that prescription costs are rising 12-18 percent per year and insurers will raise charges, create preferred drug lists and give incentives to doctors to use preferred drugs); *Health Care Costs to Balloon Next Year*, REC. (N. N.J.), June 4, 1998, at B1 [hereinafter *Balloon*] (reporting that prescription drug plans (pharmacies charging insurers) will increase 15-22 percent).

179. See *Drugs*, *supra* note 164 ("recreational/lifestyle use" and "not a medical necessity"); *Balloon*, *supra* note 178 ("pricy lifestyle drugs like Viagra"); Lerner, *supra* note 168 (quoting Dr. William Borkon, medical director of the Sexual Health Clinic at Park Nicollet Medical Center in St. Louis Park, "We're talking about recreational sex here"); *Insurers Hold Reins*, *supra* note 169 (noting "increasing role that health insurers, by default, play in deciding what is important to society" and asking where line should be drawn between medically necessary and enhancement); Craig J. Cantoni, *Should Insurance Put a Tiger in Your Tank?*, WALL ST. J., June 4, 1998, at A18 ("performance-enhancing medicine"); Kaiser Press Release, *supra* note 4, at 1; Aetna Letter, *supra* note 4, at 7 (describing "performance enhancement/lifestyle nature of Viagra").

180. See *supra* notes 39-51 and accompanying text.

181. Aetna maintains that it is impossible to establish meaningful standards. See Aetna Letter, *supra* note 4, at 3-4. The federal Medicaid program could reevaluate its decision to require state coverage "if there [was] evidence the drug [was] being misused." Zremski, *supra* note 173, at A1.

182. For example, prior to their decision to exclude coverage entirely, Kaiser considered limiting coverage to impotency caused by an underlying physical disease. See *Morrow*, *supra* note 163, at A4 (reporting that Kaiser will institute an increased co-payment and will cover only those with physical ailments or diseases).

coholism or substance abuse,<sup>183</sup> or when the cause is not sufficiently documented and diagnosed. Insurers can demand that urologists develop and follow standards of care that establish appropriate use by afflicted individuals, as opposed to “recreational” use by non-sufferers. In addition, insurers may appropriately limit the quantity prescribed.<sup>184</sup> Although insurers and Medicaid programs express confidence<sup>185</sup> that they can properly impose limits on the number of pills per month, the notion of rationing sex is unusual and new to them.<sup>186</sup>

### 3. Insurance Coverage for Other Erectile Dysfunction Treatments

Whether insurers will eventually cover Viagra generally, and in what quantity, remains to be seen. However, as decisions described in the next section reveal, the insurance coverage experience for other erectile dysfunction treatments suggests that coverage will vary substantially from plan to plan.

#### a. Is Treatment of Erectile Dysfunction Medically Necessary?

If a plan does not expressly exclude coverage for treatment of erectile dysfunction, an insured is likely to prevail against an insurer’s denial on grounds that treatment is not medically necessary, especially when the cause is organic.<sup>187</sup> For example, in *Doe v. Northwestern National Life Insurance Company*,<sup>188</sup> plaintiff sought insurance coverage for the surgical insertion of a penile prosthetic device, necessitated by diabetes-related impotency. The insurer argued that inserting the prosthesis only treated a symptom (impotency) of a preexisting condition (diabetes), but impotency was not, itself, a sickness as required under

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183. See Waldman, *supra* note 172, at B2 (limiting coverage to men with impotence caused by physical or organic problems, excluding coverage for impotence caused by mental illness or substance abuse).

184. See Wiggins, *supra* note 163, at A1 (reporting that Viagra marks the first time that its Medicaid program has ever set a dosage limit and noting concern that it may lead to increasing limitations on other drugs).

185. See *e.g.*, Goldstein, *supra* note 173 (interviewing Maryland and D.C. Medicaid officials explaining decision to cover but limit dosage); Lerner, *supra* note 169, at A1 (interviewing health plan providers asking, “Is it important to pay for men to have intercourse?” and what limits should be placed on coverage); *Insurers Hold Reins*, *supra* note 168, at A5 (discussing insurers’ increasing role in regulating sexual practices).

186. See Lerner, *supra* note 169, at A1; *Insurers Hold Reins*, *supra* note 168, at A5; McGinley, *supra* note 172 (noting federal government may give states authority to set limits on coverage); Waldman, *supra* note 172, at B2 (state to impose limit of six pills per month and limit drug to those with organic causes).

187. For example, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) limits, but does not exclude, coverage for penile implants and testicular prostheses. See 32 C.F.R. § 199.4(e)(8)(i)(E) (1998). Coverage is provided when the condition is of “organic origins (i.e., trauma, radical surgery, disease process, for correction of congenital anomaly)” and for “penile implants for organic impotency.” *Id.*

188. 355 S.E.2d 867, 868 (S.C. 1987).

the policy.<sup>189</sup> The court rejected the insurer's distinction that diabetes was the sickness rather than impotency, and relied instead on the "plain and popular" definition of sickness to conclude impotency was a covered sickness even though diabetes was a preexisting condition.<sup>190</sup>

Often impotency is due to work-related injuries or diseases, and workers' compensation cases, also relying on the medically necessary standard, suggest that treatment of erectile dysfunction is medically necessary.<sup>191</sup> Workers' compensation cases indicate that, without an express exclusion in an insurance policy, courts are likely to determine that restoration of sexual function and treating erectile dysfunction are medically necessary and not "lifestyle" treatments.<sup>192</sup>

#### b. Express Exclusions in the Insurance Contract

Like many sexual and reproductive matters, erectile dysfunction is often subject to an express exclusion within the insurance policy.<sup>193</sup> If expressly excluded, an insured's best hope is to allege an ambiguity in the insurance contract, although cases demonstrate the difficulty of establishing such an ambiguity.

One form of alleged ambiguity arises where the contract excludes a category of procedures and provides a list of such procedures as well. For example, in *Robertson v. N.N. Investors Life Insurance Co.*,<sup>194</sup> plaintiff filed suit to recover medical expenses related to insertion of a penile implant. Plaintiff's health insurance policy expressly excluded "cosmetic surgery, which term includes but is not limited to . . . penile implants . . ." <sup>195</sup> Plaintiff contended that an ambiguity existed within the contract and that the contract did not exclude certain indications for penile implants, which were not cosmetic in nature, but were med-

189. See *id.* at 868-69.

190. See *id.* at 869.

191. Employment-related causes of impotency include, among others, injury, trauma, exposure to toxins, complications of surgery. See generally Tracy Bateman, Annotation, *Workers' Compensation as Covering Cost of Penile or Similar Implants Related to Sexual or Reproductive Activity*, 89 A.L.R.4th 1057 (1992 & Supp. 1998).

192. See generally Regnier v. Industrial Comm., 707 P.2d 333 (Ariz. Ct. App. 1985) (artificial spermatocele/quadruplegic injury; also covering artificial insemination); Crain Burton Ford Co. v. Rogers, 674 S.W.2d 944 (Ark. Ct. App. 1984) (penile implant/impotence related to back injury); Freeman United Coal Mining Co. v. Industrial Comm., 410 N.E.2d 48 (Ill. 1980) (penile implant/back injury); Boyd v. DSI Transports, Inc., 575 So. 2d 909 (La. Ct. App. 1991) (penile implant/back injury—coverage for second surgery); Canas v. Maryland Cas. Co., 459 N.W.2d 533 (Neb. 1990) (penile implant/back injury); Jackson v. Greyhound Lines, Inc., 734 S.W.2d 617 (Tenn. 1987) (penile implant/crushed pelvis).

193. See *supra* text accompanying notes 96-99. Fifteen percent of health plans specifically exclude treatment or drugs for impotency. See SEGAL COMPANY, *supra* note 53.

194. 385 S.E.2d 681, 681 (Ga. Ct. App. 1989).

195. *Id.*

ically necessary.<sup>196</sup> Plaintiff argued that his penile implant corrected an organic condition, and therefore the indication for his surgery did not fall within the cosmetic surgery exclusion.<sup>197</sup> However, the court agreed with the insurer that the express exclusion controlled; the court concluded that even if plaintiff's need for the penile implant was not cosmetic, the express exclusion was "clear and unambiguous."<sup>198</sup>

Another type of ambiguity can arise when certain conditions are excluded from coverage but no list of such procedures is provided. For example, in *Longpre v. Midwest Optical Supply, Inc.*,<sup>199</sup> plaintiff sought coverage from his employee health plan for surgical insertion of a penile prosthetic device to correct his long-term impotency. Plaintiff claimed the insurance contract language was ambiguous.<sup>200</sup> Unlike the express provision in *Robertson* that excluded implants, the policy in question here excluded coverage for any procedures "related to sex transformations or sexual dysfunctions or inadequacies" but did not list any particular procedures.<sup>201</sup> The court rejected plaintiff's poorly articulated claim that "sexual dysfunction or inadequacies" exclusion was ambiguous, concluding that plaintiff's "impotency [was] clearly a sexual dysfunction or impaired functioning of his sexual organs."<sup>202</sup> Although inartful, the plaintiff probably was attempting to argue that his impotency was not a "sexual dysfunction or inadequacy" but was a symptom of an organic disease that was covered under the policy.<sup>203</sup>

## B. *Gender Dysphoria and Transsexual Surgery*

### 1. The Treatment of Gender Dysphoria

Gender dysphoria refers to a "psychological state whereby a person demonstrates dissatisfaction with their sex of birth and the sex role, as socially defined, which applies to that sex, and who request hormonal and surgical sex-reassignment."<sup>204</sup> Transgenderism<sup>205</sup> has

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196. *See id.*

197. *See id.*

198. *See id.* at 682.

199. 587 N.E.2d 948, 949 (Ohio Ct. App. 1990) (the case does not identify the etiology).

200. *See id.*

201. *Id.*

202. *Id.*

203. The argument that impotency is a covered symptom of an organic disease is exactly the opposite of the *Doe* argument that it was a disease in and of itself. *See Doe*, 355 S.E.2d at 868-69. *Doe* made the argument that it was its own disease because the plaintiff's diabetes was preexisting. *See id.* Although plaintiffs lost in these cases, most authors note a judicial bias in favor of insureds through judicial devices to construct the insurance policy to achieve the reasonable expectations of the insured. *See Hall & Anderson, supra* note 73, at 1648-49.

204. HARRY BENJAMIN INTERNATIONAL GENDER DYSPHORIA ASSOCIATION, STANDARDS OF CARE 3.4, *reprinted in* GENDER BLENDING, *supra* note 24, at 505 [hereinafter

existed throughout history;<sup>206</sup> generally, transsexuals have been mistreated and misunderstood within society.<sup>207</sup>

There is broad consensus now that transsexualism is not a "lifestyle choice" but an involuntary state marked by discordance between gender identity and sex.<sup>208</sup> Moreover, medical and surgical treatment for appropriate individuals is a well-accepted treatment. "The majority of modern behavioral scientists, regardless of their thoughts on the etiology of this disorder, agree that a diagnosis of transsexualism exists and, with a few exceptions, the majority believe that, in properly selected patients, reassignment surgery is the best way to normalize their lives."<sup>209</sup> Transsexuality occurs in approximately one in 50,000, and between 6000 to 10,000 transsexuals are estimated to live within the United States.<sup>210</sup>

Transsexualism is generally marked by a "passionate, life-long conviction that one's psychological gender — that indefinable feeling of maleness or femaleness — is opposite to one's anatomical sex."<sup>211</sup>

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STANDARDS OF CARE]. The Harry Benjamin International Gender Association is the internationally recognized professional organization for the study of transsexualism and gender dysphoria. The professional organization, named for Harry Benjamin, a pioneer in the field of gender dysphoria, first promulgated standards of care in 1979. These standards enjoy broad recognition among professionals treating gender dysphoria. See Dallas Denny & Jan Roberts, *Results of a Questionnaire on the Standards of Care of the Harry Benjamin International Gender Dysphoria Association*, in GENDER BLENDING, *supra* note 24, at 320, 322 [hereinafter *Standards of Care*]. Information on the Harry Benjamin International Gender Dysphoria Association as well as the *Standards of Care* are also available at <<http://www.tc.umn.edu/nlhome/m201/cole001/hbigda/>>.

205. Transsexualism is defined as "[t]he desire to change one's anatomic sexual characteristics to conform physically with one's perception of self as a member of the opposite sex." STEDMAN'S MEDICAL DICTIONARY 1841 (26th ed. 1995). See also Richard F. Storrow, *Naming the Grotesque Body in the "Nascent Jurisprudence of Transsexualism,"* 4 MICH. J. GENDER & L. 275 n.1 (1997); Leslie Pearlman, *Transsexualism as Metaphor: The Collision of Sex and Gender*, 43 BUFF. L. REV. 835, 841-42 and accompanying notes (1995); Debra Sherman Tedeschi, *The Predicament of the Transsexual Prisoner*, 5 TEMP. POL. & CIV. RTS. L. REV. 27, 29-34 (1995). The precise etiology of gender dysphoria is unknown. See Pearlman, *supra*, at 867-68.

206. See Dallas Denny, *Transgender: Some Historical, Cross-Cultural, and Contemporary Models and Methods of Coping and Treatment*, in GENDER BLENDING, *supra* note 24, at 33, 35-38; Storrow, *supra* note 205, at 275-278 and accompanying notes.

207. See Denny, *supra* note 206, at 33.

208. See Pearlman, *supra* note 205, at 870.

209. David A. Gilbert, M.D., et al., *Transsexual Surgery in the Genetic Female*, 15 CLINICS IN PLASTIC SURGERY 471, 471 (1988); see also Donald R. Laub, M.D., et al., *Vaginoplasty for Gender Confirmation*, 15 CLINICS IN PLASTIC SURGERY 463, 470 (1988); Storrow, *supra* note 205, at 280-84 (discussing consensus of medical authority).

210. See Gilbert, *supra* note 209, at 471.

211. Jerold Taitz, *The Law Relating to the Consummation of Marriage Where One of the Spouses is a Post-Operative Transsexual*, 15 ANGLO-AM. L. REV. 141, 143 (1986), quoted in Pearlman, *supra* note 205, at 841 & n.21. Gender dysphoria manifests in early childhood; discordance between sex and gender identity becomes more pronounced as secondary sex characteristics develop in adolescence. See Janis R. Walworth, *Sex Reassignment Surgery in Male-to-Female Transsexuals: Client Satisfaction in Relation to Selection*



Although gender dysphoria occurs in both men and women equally, men (in the United States) present for treatment more frequently.<sup>212</sup>

The costs, the length of time, and the discomfort associated with sex-reassignment surgery are substantial, but for some, the intensity of dissatisfaction compels treatment nevertheless.<sup>213</sup> Medical treatments include hormonal therapy<sup>214</sup> and surgical sex-reassignment.<sup>215</sup> Extensive pre-operative and post-operative psychological treatment and

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*Criteria*, in GENDER BLENDING, *supra* note 24, at 353; Gilbert, *supra* note 209, at 472. Females have an easier adjustment in early childhood because of social tolerance of tomboyishness. *See id.*

212. *See* Gretchen Fincke and Roger Northway, *Patterns in and Treatments for Gender Dysphoria*, in GENDER BLENDING, *supra* note 24, at 383, 387-88. This is a Western phenomenon. In China, demand for female-to-male surgery outnumbers male-to-female. *See* Bonnie Bullough et al., *Introduction to Counseling and Treatment*, in GENDER BLENDING, *supra* note 24, at 371.

Gilbert reports that the incidence of male-to-female transsexuals seeking medical intervention has historically been much higher but that “[r]ecently there has been a dramatic shift in the ratios,” which he attributes to “an expanded public awareness regarding transsexualism, the persistence of transsexuals to undergo definitive genital surgery, the stability of female transsexuals, and a renewed enthusiasm and hope for advancement in phalloplasty surgery.” Gilbert, *supra* note 209, at 472.

213. *See* Gilbert, *supra* note 209, at 472; Lisa Middleton, *Insurance and the Reimbursement of Transgender Health Care*, in GENDER BLENDING, *supra* note 24, at 455; Karyn Hunt, S.F. *Weights Coverage for Sex-change Operations*, SAN DIEGO UNION-TRIB., Sept. 26, 1996, at A2 (surgery costs between \$10,000 and \$20,000, not including extensive psychiatric evaluations and life-long hormonal treatment required). *See also* *Maggert v. Hanks*, 131 F.3d 670, 671 (7th Cir. 1997) (“Someone eager to undergo this mutilation is plainly suffering from a profound psychiatric disorder.”).

214. Hormonal sex reassignment refers to the administration of androgens to genotypic and phenotypic females, and the administration of estrogens and/or progesterones to genotypic and phenotypic males, for the purpose of effecting somatic changes in order for the patient to more closely approximate the physical appearance of the genotypically other sex.

STANDARDS OF CARE, *supra* note 204.

215. Genital surgical sex reassignment refers to surgery of the genitalia and/or breasts performed for the purpose of altering the morphology in order to approximate the physical appearance of the genetically other sex in persons diagnosed as gender dysphoric. Such surgical procedures as mastectomy, reduction mammoplasty, augmentation mammoplasty, castration, orchidectomy, penectomy, vaginoplasty, hysterectomy, salpingectomy, vaginectomy, oophorectomy and phalloplasty in the absence of any diagnosable birth defect or other medically defined pathology, except gender dysphoria, are included in this category labeled sex reassignment.

STANDARDS OF CARE, *supra* note 204. Also included are non-genital surgical procedures (i.e., to the nose, throat, chin, cheeks, etc.) conducted for the purpose of achieving a more masculine or feminine appearance. *See id.* *See also* Tedeschi, *supra* note 205, at 32 (describing surgical procedures); Stanley H. Biber, *Current State of Transsexual Surgery: A Brief Overview*, in GENDER BLENDING, *supra* note 24, at 374-376 (describing surgical procedures).

evaluation are rigorous and ensure an unequivocal and prolonged commitment to the procedure.<sup>216</sup>

The criteria for surgery include (1) recommendation in writing by two behavioral scientists, one of whom has know[n] the patient in a therapeutic relationship for 6 months; (2) a successful cross-living test over a 1-year period; and (3) legal, social, psychological, sexual and (exogenous) endocrine success during cross-living.<sup>217</sup>

These well-developed criteria, the stigma of transsexualism, and the rigors of treatment make it unlikely that unnecessary and ill-considered surgery is performed often.

## 2. *Insurance Coverage for Gender Dysphoria*

Defining the status of transsexuals and the treatment of transsexualism pose particular analytical difficulties for medicine and law generally.<sup>218</sup> Health insurers must determine whether transgenderism is a physical or psychological illness, a life choice, or a naturally occurring gender state along a continuum of gender.<sup>219</sup>

### a. Insurance Coverage

Medical coverage for transsexual surgery and/or hormonal treatment is very uncommon, but reportedly increasing.<sup>220</sup> It is typical, but

216. See STANDARDS OF CARE, *supra* note 204. Some criticize the conservatism of the standards. See Nancy Reynolds Nangeroni, *SRS Tomorrow: The Physical Continuum*, in GENDER BLENDING, *supra* note 24, 344, 349-50 (favoring more liberal self-choice).

217. Laub, *supra* note 209, at 463 (referring to the Harry Benjamin International Gender Dysphoria Association Standards of Care).

218. See Louis H. Swartz, *Law and Transsexualism*, in GENDER BLENDING, *supra* note 24, at 422; See generally Richard Green, *Transsexualism and the Law*, 22 BULL. AM. ACAD. PSYCHIATRY & L. 511 (1994) (legal issues confronting transsexualism include, among others, privacy, name changing, employment discrimination, marriage, parenting, treatment in prisons, insurance coverage, military service); Pearlman, *supra* note 205, at 851-864; Storrow, *supra* note 205, at 285-332 (marriage, parenting, name and birth certificate changes, prisoner rights, employment discrimination); Tedeschi, *supra* note 205, at 32-35.

219. There is an increasing sentiment that transsexualism is not a disease but rather a gender identity along a spectrum that is not binary. See Pearlman, *supra* note 205, at 843-44, 871-72; Nangeroni, *supra* note 216, at 348-49; Denny, *supra* note 206, at 40; Holly Boswell, *The Transgender Paradigm Shift Toward Free Expression*, in GENDER BLENDING, *supra* note 24, at 53, 56.

220. See Gilbert, *supra* note 209, at 486 (noting increasing "willingness of insurance companies to compensate for associated surgical procedures"); E-mail from Judy Van Maasdam, former executive director of the Harry Benjamin International Gender Dysphoria Association, coordinator of the Gender Dysphoria Program, Palo Alto, California (formerly the Stanford University Gender Identity Program), (June 18, 1998) [hereinafter Van Maasdam E-mail] (on file with author). Ms. Van Maasdam stated, "Coverage for hormonal and surgical therapies varies with each insurance contract. Some specifically exclude treatment, while other insurers characterize the treatments as cosmetic and exclude coverage on that basis. In my twenty years in the field, I have noted that coverage is improving." *Id.* Ms. Van Maasdam also noted that HMOs and managed care providers rarely cover the surgery, and that some, like Kai-

not universal, for health insurance policies to expressly exclude coverage for transgender health care, especially in managed care and HMOs.<sup>221</sup> However, once an individual changes his or her name and gender on medical records, coverage for otherwise routinely prescribed hormonal therapy may not be noticed as being related to the excluded coverage for treatment of transgender conditions and sex change.<sup>222</sup>

In those unusual insurance contracts that do not expressly exclude sex-reassignment surgery and/or hormonal treatment, courts are likely to find the treatment medically necessary and not experimental.<sup>223</sup> In *Davidson v. Aetna Life & Casualty Insurance Co.*,<sup>224</sup> plaintiff sought treatment for male-to-female gender dysphoria under an employer-sponsored health plan.<sup>225</sup> Prior to filing the claim, the plaintiff underwent hormonal treatment in anticipation of sex-reassignment surgery.<sup>226</sup> The relevant policy exclusion provided: "Cosmetic Surgery — Any of the listed expenses incurred in connection with cosmetic surgery will be considered Covered Medical Expenses

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ser, specifically exclude it. See *id.* Individual patients may be successful in challenging insurers in some cases. See *id.* See also Gianna E. Israel and Donald E. Tarver, *Genital Reassignment Surgery*, in TRANSGENDER CARE *supra* note 24, at 90 (1997) ("In the United States getting insurance company coverage for genital-reassignment procedures is considerably more difficult [than in Europe], although not impossible."). Doctors sometimes prescribe hormone therapy following surgery without insurance company challenge because the hormones are routinely prescribed for other conditions as well. Telephone Interview with Lisa Middleton, Claims Executive, Workers' Compensation (insurance specialist and author) (August 11, 1998) [hereinafter Middleton Interview].

221. See CHOICES, *supra* note 52, at 141 n.19 (noting that all of the comprehensive plans reviewed for his study excluded sex-reassignment surgery as a treatment category); Lisa Middleton, *Insurance and the Reimbursement of Transgender Health Care*, in TRANSGENDER CARE, *supra* note 24, at 215; Israel & Tarver, *supra* note 220, at 90. See, e.g., *Longpre v. Midwest Optical Supply, Inc.*, 587 N.E.2d 948 (Ohio Ct. App. 1990) (excluding coverage for procedures "related to sex transformations or sexual dysfunctions or inadequacies"). CHAMPUS expressly excludes coverage for "[t]ranssexualism or such other conditions as gender dysphoria" except in "one very limited exception" for "congenital anomaly . . . to correct sex gender confusion . . . which has been documented to be present at birth." 32 C.F.R. § 199.4(e)(7) (1998).

222. Middleton Interview, *supra* note 220. Ms. Middleton explains that both premarin (female hormones) and testosterone injections (male hormones) have other common applications in males and females and so do not arouse suspicion after the medical record and name have been changed to reflect the sex change. See *id.*

223. As to its general acceptance as an appropriate treatment for gender dysphoria, see Laub, *supra* note 209, at 463, 470; Gilbert, *supra* note 209, at 486; FRIEDEMANN PFÄFFLIN & ASTRID JUNGE, SEX REASSIGNMENT THIRTY YEARS OF INTERNATIONAL FOLLOW-UP STUDIES AFTER SEX REASSIGNMENT SURGERY: A COMPREHENSIVE REVIEW, 1961-1991 (Roberta B. Jacobson & Alf B. Meier trans., Sympson Publishing) (on file with author). Despite general acceptance, insurers reportedly continue to insist that surgical treatment is experimental. See Israel & Tarver, *supra* note 220, at 90-91; Middleton, in TRANSGENDER CARE, *supra* note 221, at 216-17.

224. 420 N.Y.S.2d 450, 451 (Sup. Ct. 1979).

225. See *id.*

226. See *id.*

only if the cosmetic surgery is necessary for the repair of a non-occupational injury which occurs while the family member is covered for this benefit."<sup>227</sup>

The insurer argued that gender dysphoria was cosmetic surgery not necessitated by a non-occupational injury.<sup>228</sup> However, the court considered expert testimony that transsexual surgery was not cosmetic because it treated an underlying medical condition.<sup>229</sup> Importantly, the court noted that while transsexualism was once thought to be a mere psychological disturbance, that was no longer the case: "current theories suggest that an inconsistency in the so-called psychosexual brain center causes gender to be perceived as opposite to the morphology of the sexual apparatus."<sup>230</sup> The court rejected the insurer's expert evidence that there was "nothing physically wrong with a transsexual's body" and that the problem was "mental."<sup>231</sup>

The court also explained that the arduous and radical procedure was rarely sought and even more infrequently done, implying that it was never done for cosmetic purposes, such as to "improve muscle tone or physical appearance."<sup>232</sup> Rather, the court explained, the surgery corrected a "psychological defect" and "is of a medical nature," not of a "strictly cosmetic nature."<sup>233</sup>

As in the case of impotency, absent an express exclusion, courts generally regard the treatment of sexual dysfunction or gender dysphoria as medically necessary.<sup>234</sup> The hurdle more frequently encountered is an express exclusion for treatment.

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227. *Id.*

228. *See id.*

229. *See id.* at 452.

230. *Id.* (quoting Michael S. Baggish, *Testing and Treating Sex Change Candidates*, 12 CONTEMP. OB/GYN 83-97 (1978)).

231. *Id.* at 453.

232. *Id.* *See also* Leane Renee, *Impossible Existence: The Clash of Transsexuals, Bipolar Categories, and Law*, 5 AM. U. J. GENDER & L. 343, 382 (1997) (describing financial and physical hardships of undergoing surgery).

233. *Id.*

234. Judicial decisions in favor of coverage are more likely to create broader coverage than legislative efforts. *See* Stephen Whittle, *Legislating for Transsexual Rights: A Prescriptive Form*, in GENDER BLENDING, *supra* note 24, at 430. Legislative initiatives for mandated coverage are unlikely in light of the negative public attitude toward transsexuals and public discomfort with the radical treatment. *See id.* In fact, the pervasive discriminatory attitude makes judicial, piecemeal decisionmaking more advantageous. *See* Louis H. Swartz, Abstracts of the XV Harry Benjamin International Gender Dysphoria Association Symposium, *Advantages of an Incrementalist (Piecemeal) Approach to Legal Aspects of Sex Reassignment and Transsexuality in the US, UK, and Other Common Law Jurisdictions*, 1 INT'L J. OF TRANSGENDERISM, Oct.-Dec. 1997 (visited August 10, 1998) <<http://www.symposium.com/ijt/hbigda/vancouver/swartz.html>> (on file with author). However, the City and County of San Francisco has begun developing guidelines to implement mandated coverage under public employee insurance contracts. *See* Hunt, *supra* note 213, at A2. Judy Van Maasdam explains that San Francisco has mandated public employee coverage but that guidelines are still being

### b. Medicaid Coverage

Demands for coverage of transsexual sex-reassignment surgery have been litigated several times under Medicaid with mixed results. Some courts have upheld the state's right to exclude the treatment as experimental and not medically necessary, while others have held the express exclusions of transgender treatment in state Medicaid laws arbitrary and capricious.<sup>235</sup>

In 1992, the New Jersey Division of Medical Assistance and Health Services decided to cover a female-to-male transsexual's phalloplasty.<sup>236</sup> The forty-two-year-old patient had commenced psychotherapy and hormonal treatment at age twenty-eight and had undergone a hysterectomy and a mastectomy at the time of the Medicaid request.<sup>237</sup> Experts and treating physicians persuaded the court that sex-reassignment surgery was the best and most appropriate treatment for the patient and one expert wrote, "denying this patient phalloplasty at this time would be unwise both medically and psychologically."<sup>238</sup>

The court noted that under the Medicaid Act, a state's voluntary participation with the federal Medicaid program meant the state agreed to comply with federal statutory and regulatory requirements of the program.<sup>239</sup> While the act vests discretion in each state to design its program, a state may not be arbitrary and capricious in its determinations.<sup>240</sup> New Jersey contended it did not have an improper per se exclusion based solely on the diagnosis, but rather limited coverage for sex-reassignment surgery to rare instances such as congenital malformations of genitalia.<sup>241</sup> Moreover, New Jersey argued that sex-reassignment surgery remained experimental. The court rejected

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promulgated and the coverage currently has not been implemented. Van Maasdam E-mail, *supra* note 220.

235. For cases ruling favorably under Medicaid, see *Pinneke v. Preisser*, 623 F.2d 546, 549 (8th Cir. 1980) (arbitrary and capricious to decline medically necessary care solely based upon diagnosis); *G.B. v. Lackner*, 145 Cal. Rptr. 555, 559 (Cal. Ct. App. 1978) (not cosmetic nor experimental); *Doe v. Lackner*, 145 Cal. Rptr. 570, 572 (Cal. Ct. App. 1978) (medically necessary and not cosmetic); *Doe v. State Department of Public Welfare*, 257 N.W.2d 816, 820 (Minn. 1977) (cannot arbitrarily deny treatment solely on the basis of diagnosis); *M.K. v. Division of Medical Assistance and Health Services, State of New Jersey*, No. DMA 2345-91, 1992 WL 280789, at paras. 50-61 (N.J. Adm. May 7, 1992).

For cases declining coverage, see *Rush v. Johnson*, 565 F. Supp. 856, 865-66 (N.D. Ga. 1983) (experimental and lacking medical consensus as to effectiveness); *Dennis R. v. Lavine*, 347 N.E.2d 893, 895 (N.Y. 1976) (denial not arbitrary and capricious on specific facts of case).

236. See *M.K. v. Division of Med. Assistance and Health Serv.*, 1992 WL 280789, at paras. 50-61.

237. See *id.*

238. *Id.*

239. See *id.*

240. See *id.*

241. See *id.*

the state's arguments and specifically held that sex-reassignment surgery was no longer experimental but had become "medically appropriate" and "necessary" for some individuals.<sup>242</sup> Despite continued challenges, state Medicaid statutes and regulations persist in expressly excluding sex-reassignment surgery.<sup>243</sup>

### c. Prisoner Cases

Prison medical care cases decided under the Eighth Amendment<sup>244</sup> represent a fair number of transgender treatment cases and also help define the landscape as to whether gender dysphoria treatment is regarded as medically necessary, cosmetic, or experimental.<sup>245</sup> Recently, in *Maggert v. Hanks*,<sup>246</sup> the Seventh Circuit issued a broad opinion that severely limited a prisoner's right to treatment for gender dysphoria, even though the court accepted the view that the treatment was both appropriate and not experimental. Notably, Judge Richard Posner reasoned that under the Eighth Amendment, prisoners were not entitled to better treatment than private insureds, even

242. *See id.*

243. *See, e.g.*, ALASKA ADMIN. CODE tit. 7, § 43.385 (1997) (excluding transsexual surgical procedures for gender change or reassignment); ARIZ. ADMIN. CODE § R9-27-203 (1997) (excluding sex-change operations, reversal of voluntarily induced infertility); ILL. ADMIN. CODE tit. 89, § 140.6 (1998) (excluding artificial insemination and medical or surgical transsexual treatment); MASS. REGS. CODE tit. 114.1, § 36.02 (excluding sex-reassignment as "experimental or unproven"); MASS. REGS. CODE tit. 130, §§ 410.405, 405.418, 415.408 423.415, 433.404, 433.440 (1998) (excluding sex-reassignment surgery and all pre- and post-hormone treatment as experimental, unproven or otherwise unnecessary); N.Y. COMP. CODES R. & REGS. tit. 18, § 505.2 (1998) (excluding gender reassignment including care, services, drugs or supplies); OHIO ADMIN. CODE § 5101:3-13-05 (1998) (excluding cosmetic surgery such as "sex change"); OR. ADMIN. R. 410-120-1200 (1996) (excluding transsexual surgery or related services); PA. CODE tit. 55, § 1163.59 (1998) (excluding transsexual surgical procedures); WASH. ADMIN. CODE § 388-86-200 (1998) (excluding treatment for gender dysphoria, infertility, frigidity, or impotency); Wis. ADMIN. CODE § HFS 107.03 (1997) (expressly excluding transsexual surgery and hormonal treatment, treatment for impotence, penile prostheses, infertility treatment, artificial insemination, reversal of sterilizations).

244. "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments afflicted." U.S. CONST. amend. VIII. *See Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (denial of treatment for serious medical and psychological afflictions violates Eighth Amendment).

245. *See, e.g.*, *Farmer v. Hawk*, 991 F.Supp. 19 (D.D.C. 1998) (recognizing that transsexualism is a serious medical condition for which treatment is required under the Eighth Amendment); *Brown v. Zavaras*, 63 F.3d 967 (10th Cir. 1995) (prisoner states a claim for deliberate indifference to serious medical need where prison officials do not offer treatment for gender dysphoria). *See generally* Tedeschi, *supra* note 205, at 35-44 (discussing prisoner cases: *Merriwether v. Faulkner*, 821 F.2d 408 (7th Cir.), *cert. denied*, 484 U.S. 935 (1987); *Lamb v. Maschner*, 633 F. Supp. 351 (D. Kan. 1986); *Supre v. Ricketts*, 596 F. Supp. 1532 (D. Colo. 1984), *rev'd*, 792 F.2d 958 (10th Cir. 1986); *Phillips v. Michigan Dep't of Corrections*, 731 F. Supp. 792 (W.D. Mich. 1990), *aff'd per curiam*, 932 F.2d 969 (6th Cir. 1991); *Farmer v. Carlson*, 685 F. Supp. 1335 (M.D. Pa. 1988); *Farmer v. Haas*, 927 F.2d 607 (7th Cir. 1991)).

246. *See generally* *Maggert v. Hanks*, 131 F.3d 670 (7th Cir. 1997) (Posner, J.).

when the treatment sought was medically appropriate and necessary.<sup>247</sup>

In *Maggert*, the prisoner filed suit against prison officials who denied him estrogen therapy to treat gender dysphoria.<sup>248</sup> Prison officials refused to prescribe estrogen, instead offering psychotherapy.<sup>249</sup> Although a material question of fact existed as to the actual diagnosis of gender dysphoria and the appropriateness of treatment in this case, Judge Posner seized the opportunity, explaining "there is a broader issue, having to do with the significance of gender dysphoria in prisoners' civil rights litigation, that we want to address."<sup>250</sup> The court had no difficulty concluding that gender dysphoria "[was] a serious psychiatric disorder, as we know because the people afflicted by it [would] go to great lengths to cure it if they [could] afford the cure."<sup>251</sup> The court then acknowledged the cure was not psychotherapy, but hormonal treatment followed by surgical removal of the sex organs and reconstructive surgery, and that no other "less drastic" or "less costly" treatment had been successful.<sup>252</sup> Thus, the court acknowledged that gender dysphoria constituted a serious medical condition for which hormonal and surgical treatment was medically appropriate and necessary.<sup>253</sup>

The court next reviewed how transsexuals outside of prison were treated under standard insurance policies,<sup>254</sup> CHAMPUS,<sup>255</sup> and Medicaid,<sup>256</sup> concluding:

In general then, you have to pay for the treatment yourself; and the total cost, which can easily reach \$100,000, puts the treatment beyond the reach of a person of average wealth. Withholding from a prisoner an esoteric medical treatment that only the wealthy can afford does not strike us as a form of cruel and unusual punishment. It is not unusual; and we cannot see what is cruel about refusing a benefit to a person who could not have obtained the benefit if he had refrained from committing crimes. We do not want

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247. The economics-based opinion, penned by the Honorable Richard Posner, is consistent with his thoughts in *Sex and Reason*, where Judge Posner aimed to "expound a specific economic theory of sexuality." POSNER, *supra* note 7, at 5. Judge Posner acknowledged that economics provided a frame of reference for his legal reasoning, explaining, "law . . . could not be understood or improved without a healthy dose of economics." *Id.* at 437.

248. See *Maggert*, 131 F.3d at 671.

249. See *id.* at 670-71.

250. *Id.*

251. *Id.*

252. See *id.* (citing only one study reporting success with a "nonradical" treatment) (B.K. Puri & I. Singh, *The Successful Treatment of a Gender Dysphoric Patient with Pimozide*, 30 AUSTRALIAN & N. Z. J. PSYCH. 422, 423 (1996)).

253. See *Maggert*, 131 F.3d at 671.

254. See *supra* Part III.B.2.

255. See *supra* note 221.

256. See *supra* Part III.B.2.b.

transsexuals committing crimes because it is the only route to obtaining a cure.<sup>257</sup>

The court then compared the "seriousness" of this condition and its cost to unknown, but more serious conditions, apparently as insurers do when valuing treatment of matters of sexual health and reproduction generally:

It is not the cost per se that drives this conclusion. For life-threatening conditions, Medicaid and other public-aid, insurance, and charity programs authorize treatments that often exceed \$100,000. Gender dysphoria is not, at least not yet, generally considered a severe enough condition to warrant expensive treatment at the expense of others than the person suffering from it.<sup>258</sup>

On one hand, the court acknowledged that gender dysphoria was a serious psychiatric condition, not a lifestyle option, and effective medical treatment was available and appropriate. Nevertheless, the court concluded (apparently like the vast majority of insurers) the sexual well-being of these individuals did not represent a "severe enough condition to warrant expensive treatment."<sup>259</sup> This conclusion is difficult to reconcile with the court's opinion that gender dysphoria is a "serious psychiatric disorder" for which individuals go to "great lengths" to seek a cure.<sup>260</sup> Moreover, the court erroneously assumed that in this case treating the disorder would result in a "great expense," when, in fact, the estrogen therapy the patient-prisoner sought was an item of relatively small monthly cost.<sup>261</sup>

#### d. Unsympathetic Insurers and Sympathetic Courts

While insurers and government health care providers resist health care coverage for erectile dysfunction and gender dysphoria, two conditions that affect sexual satisfaction and respond to medical intervention, courts have been somewhat more compassionate. Judi-

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257. *Maggert*, 131 F.3d at 672.

258. *Id.*

259. *Id.*

260. In some ways, the bias against mental health treatment is reflected in this decision. Physical health is more valued. I for one would prefer intense physical pain over intense mental anguish and a shorter life with sound mental health over a long, psychiatrically disabled life. In short, the notion that insurance should expend its greatest resources on life-threatening conditions but leave other insureds in mental agony is not necessarily desirable. A more humane approach is possible. See, e.g., *Farmer v. Hawk*, 991 F. Supp. 19 (D.C. 1998) (approving a prison policy that maintained transsexuals at the level of change at which they entered the prison system).

261. See Phillip Matier & Andrew Ross, *Move to Cover City Workers' Sex Changes*, SF. CHRON., Sept. 23, 1996, at A15 ("[C]osts of hormonal treatments are 'relatively low' . . . about \$100 a month") (discussing *Maggert*, 131 F.3d at 671). The court also acknowledged the relative rarity of the condition, thus making the low-cost hormone therapy a low-demand item in the prison population. See *Maggert*, 131 F.3d at 671 ("gender dysphoria is a rare condition"). Moreover, the court ignored the fact that prisoners cannot earn the money to cover hormonal therapy or acquire it except through the prison doctors, unlike non-prisoners. See *id.*



cial decisions acknowledge that treatment of sexual dysfunction and gender dysphoria are indeed matters of medical necessity,<sup>262</sup> and if not excluded by the specific language of the contract or governing law, treatment should be covered under standard policies.<sup>263</sup> Coverage requests under Medicaid laws and prisoner requests under the Eighth Amendment have been mixed, but individual judges show a surprising depth of understanding and compassion.<sup>264</sup>

Judge Posner wrote, "judges know next to nothing about the subject [of sex] beyond their own personal experience."<sup>265</sup> And yet, in contrast to insurers, the opinions of many judges concerning medical treatment coverage reflect a judicial recognition that sexual well-being is an important health matter.

#### IV. REPRODUCTIVE HEALTH CARE COVERAGE

In 1994, the Alan Guttmacher Institute published the "first large-scale, comprehensive study of private insurance coverage of reproductive health care services."<sup>266</sup> The study found that coverage for pregnancy, various reversible contraceptive methods, contraceptive sterilization, induced abortion, and infertility treatment was disconcertingly variable given the importance of such coverage to women's health status.<sup>267</sup> Overall, it noted that HMOs and other managed care plans generally offered more comprehensive coverage than traditional indemnity plans, but that all plans were adequately deficient to justify calling for national health care reform.<sup>268</sup> As a general rule, insurers do not favor preventative medicine.<sup>269</sup> When it comes to sexual and reproductive health, the preference for surgery and disease treatment ignores the cost-savings and health benefits associated with preventative medicine.<sup>270</sup> For example, although insurance contracts now cover the treatment of sexually transmitted diseases, unlike the contracts written a few decades ago, thirty percent of traditional indemnity plans do not cover routine, appropriate screening for sexually transmitted diseases that are vital to diagnosing these silent,

262. See *supra* notes 224, 236, 245 and accompanying text.

263. See *supra* Part III.B.2.

264. See Storrow, *supra* note 205, at 284 ("Courts recognize the unique issues of transsexuals and reach outcomes of a surprisingly humanitarian character.").

265. POSNER, *supra* note 7, at 1.

266. UNEVEN & UNEQUAL, *supra* note 8, at 5. The institute surveyed conventional indemnity plans, preferred provider organizations and all 73 Blue Cross/Blue Shield plans, point-of-service networks, and health maintenance organizations. See *id.*

267. See *id.* at 25. See also Waysdorf, *supra* note 65, at 756-57.

268. See UNEVEN & UNEQUAL, *supra* note 8, at 25.

269. See Michael H. Cohen, *Holistic Health Care: Including Alternative and Complementary Medicine in Insurance and Regulatory Schemes*, 38 ARIZ. L. REV. 83, 154-55 & n.507 (1996); Caroline W. Jacobus, *Legislative Responses to Discrimination in Women's Health Care: A Report Prepared for the Commission to Study Sex Discrimination Statutes*, 16 WOMEN'S RTS. L. REP. 153, 168 (1995).

270. See generally Trussell, *supra* note 8; see also Roberts, *supra* note 8, at 7.

destructive diseases.<sup>271</sup> An examination of reproductive health issues (largely, but not exclusively, female health issues) demonstrates the irrationality of health coverage for reproductive health.

#### A. *Pregnancy*

Each year, seven percent of women between the ages of fifteen and forty-four become pregnant and give birth.<sup>272</sup> The average American woman bears two children during her lifetime.<sup>273</sup> Prenatal and obstetrical care preserves the life and health of both mother and child, as pregnancy and childbirth have the potential for fatal complication.<sup>274</sup>

Prior to enactment of the Pregnancy Discrimination Act of 1978 (PDA),<sup>275</sup> insurers commonly took the position that pregnancy was

271. The Alan Guttmacher Institute reports that approximately 30% of employer-sponsored indemnity plans do not cover routine STD screening while 98% of HMOs do cover screening. See UNEVEN & UNEQUAL, *supra* note 8, at 9 (also reporting on coverage rates for mammograms, pap smears and annual exams). A Johns Hopkins University study released in 1998 now urges testing every six months for sexually active adolescents females. See Gale R. Burstein, M.D., MPH, et al., *Incident Chlamydia Trachomatis Infections Among Inner-city Adolescent Females*, 280 JAMA 521, 524 (1998). Screening is essential to preserve the reproductive health of young women. See *id.* For example, chlamydia has a relative lack of symptoms at onset but if untreated leads to chronic pelvic inflammatory disease and infertility. See *id.* Because it is a silent disease destroying the reproductive health of young women, the Centers for Disease Control now recommend that sexually active women under 20 be screened annually. See *id.* See also Sarah Yang, *Biannual Chlamydia Screenings Urged/ Research: A Study of 3,200 Females Shows High Rates of Infection and Reinfection*, L.A. TIMES, Aug. 17, 1998, available in 1998 WL 2455425.

272. See Alan Guttmacher Institute, *Facts in Brief: Contraceptive Services* (visited June 10, 1998) <<http://www.agi-usa.org/pubs/fb18.html>> [hereinafter *Contraceptives*]. Many more women become pregnant than actually deliver; fifty-six percent of pregnancies are unplanned, and of those, 43% end in birth, 44% in abortion and 13% in miscarriage. See *id.* See also Law, *supra* note 69, at 364.

273. See *Contraceptives*, *supra* note 272.

274. Access to affordable maternal health care and insurance coverage saves lives and preserves health. See Margaret M. Donahoe, *Our Epidemic of Unnecessary Cesarean Sections: The Role of the Law in Creating It, the Role of the Law in Stopping It*, 11 WIS. WOMEN'S L.J. 197, 200-208 (1996) (discussing nature of complications and mortality rates); Waysdorf, *supra* note 65, at 754-67; Geetanjali Misra, et al., *Poor Reproductive Health and Environmental Degradation: Outcomes of Women's Low Status in India*, 6 COLO. J. INT'L ENVTL. L. & POL'Y 273, 284 (1995) (discussing impact of poverty on maternal and child health).

275. The Pregnancy Discrimination Act, enacted in 1978 amended Title VII, covering employment based group health plans, to provide:

(k) The terms 'because of' or 'on the basis of sex' include, but are not limited to, because of or on the basis of pregnancy, childbirth, or related medical conditions; and women affected by pregnancy, childbirth, or related medical conditions shall be treated the same for all employment-related purposes, including receipt of benefits under fringe benefit programs, as other persons not so affected but similar in their ability or inability to work, and nothing in section 2000e-2(h) of this title shall be interpreted to permit otherwise. This subsection shall not require an employer to pay for health

not a disease, but a voluntary condition, and treatment for it was not medically necessary.<sup>276</sup> Many insurance contracts contained express exclusions or limited maternity coverage.<sup>277</sup> Insurers providing some maternity benefit coverage frequently instituted nine- or ten-month waiting periods, presumably to avoid the risk of adverse selection.<sup>278</sup> These provisions impinged upon job-mobility.<sup>279</sup>

Unlike policies written a few decades ago, most health plans now routinely cover pregnancy, although coverage is not universal.<sup>280</sup> Well over ninety percent of today's health plans cover pregnancy, even when not governed by federal law.<sup>281</sup> The improvement is due largely to the enactment of PDA, though there had been some gradual voluntary improvement prior to enactment.<sup>282</sup> The PDA prohibits discrimination in the provision of employer sponsored health benefits "on the

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insurance benefits for abortion, except where the life of the mother would be endangered if the fetus was carried to term, or except where medical complications have arisen from an abortion: Provided, That notion herein shall preclude an employer from providing abortion benefits or otherwise affect bargaining agreements in regard to abortion.

42 U.S.C. § 2000e(k) (1994).

276. See ROBERT CUNNINGHAM III & ROBERT M. CUNNINGHAM JR., *THE BLUES: A HISTORY OF THE BLUE CROSS AND BLUE SHIELD SYSTEM* 25 (1997) (describing Depression era plans: "Coverage of hospitalized maternity care was seen as an especially poor risk and a threat to group stability because hospitalization was, in effect, planned in advance; the hospitalization and payment for it were a matter of choice"). See also Lucinda Finley, *Choice and Freedom: Elusive Issues in the Search for Gender Justice*, 96 *YALE L.J.* 914, 929-30 (1987) (reviewing DAVID L. KIRP, ET AL. *GENDER JUSTICE* (1986)) ("the 'voluntary,' 'inexpensive' and 'welcome' arguments for denying economic security to pregnant working women and their families are heavily value-laden").

277. Writing of plans in the 1950s, "[s]ome plans exclude maternity benefits, others provide them without limitation, and still others provide such benefits after a defined period, as for example nine months of insurance." See Smith, *supra* note 38, at 78; CUNNINGHAM & CUNNINGHAM, *supra* note 276, at 25.

278. See CUNNINGHAM & CUNNINGHAM, *supra* note 276, at 25 ("Gradually most of the Plans began to cover maternity services, some with waiting periods and extra charges, and some without."). See, e.g., *Mutual of Omaha Ins. Co. v. Lang*, 190 So. 2d 730 (Ala. Ct. App. 1966) (premature birth is covered where policy provided for ten month or one "which would have normally resulted in childbirth more than ten months after" policy date); *American Life Ins. Co. v. Schrimsher*, 42 So. 2d 601 (Ala. Ct. App. 1949) (provision requiring policy to be in force for ten months).

279. See *Lawrence v. Northwestern Nat'l Life Ins. Co.*, 716 F. Supp. 883, 885-86 (D. Md. 1989) (pregnancy not covered where husband knew wife "might" be pregnant before policy's effective date); *Vance v. Aetna Life Ins. Co.*, 714 F. Supp. 203, 206 (E.D. Va. 1989) (wife's pregnancy not covered where she was treated for condition before effective date of insurance); *Lovett v. American Family Life Ins. Co.*, 131 S.E.2d 70, 71 (Ga. Ct. App. 1963) (where ectopic pregnancy commenced prior to effective date of policy, insured was not covered under a clause covering "sickness due to a disease originating during the term" even though diagnosis occurred after effective date).

280. In a 1984 study of smaller plans, not covered by the PDA, only 18% of smaller plans provided voluntary coverage. See UNEVEN & UNEQUAL, *supra* note 8, at 12. Today, that number is 97%. See *id.*

281. See *id.*

282. Writing of Blue Cross/Blue Shield plans during the Depression era:

basis of pregnancy, childbirth, and related medical conditions."<sup>283</sup> In 1983, the United States Supreme Court ruled the PDA also applied to dependents of insureds under employer benefit plans.<sup>284</sup>

Issues related to pregnancy discrimination continue, especially regarding preexisting condition exclusions<sup>285</sup> and the "drive through delivery" discharge demands of some insurers and many HMOs.<sup>286</sup> In order to overcome the pregnancy-related insurance problems caused by preexisting condition clauses and job mobility, Congress recently amended ERISA to provide that, "[a] group health plan, and health insurance issuer offering group health insurance coverage may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition."<sup>287</sup> Beginning in 1998, federal law requires group health plans and group health plan insurers to cover at least forty-eight hours of hospital benefits for mother and child following normal vaginal deliveries and ninety-six hours following cesarean sec-

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To everybody's surprise, these experiments [in maternity coverage] were generally successful. Nobody decided to have a baby just to con a Plan into paying the hospital bill, and birth rates during the Depression were low. Gradually most of the Plans began to cover maternity services, some with waiting periods and extra charges, and some without.

CUNNINGHAM & CUNNINGHAM, *supra* note 276, at 25.

283. 42 U.S.C. § 2000e(k) (1994). See Law, *supra* note 69, at 363. Passage of the act overruled *General Electric Co. v. Gilbert*, 429 U.S. 125 (1976), in which the Court ruled that exclusion of pregnancy from an employer's disability plan did not violate Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e. See *Islesboro School Committee et al. v. Califano* 593 F.2d 424, 430 (1st Cir. 1979). *Gilbert* relied on *Geduldig v. Aiello*, 417 U.S. 484 (1974), in which the Court upheld, as nondiscriminatory, the exclusion of pregnancy coverage from a comprehensive health insurance plan of a public employer. See *Gilbert*, 429 U.S. 125 *passim*. In these cases, the Court reasoned that discrimination on the basis of pregnancy was not a gender-based classification. See *id.* For articles analyzing *Geduldig* and noting its continued vitality, see Shannon E. Liss, *The Constitutionality of Pregnancy Discrimination: the Lingering Effects of Geduldig and Suggestions for Forcing its Reversal*, 23 N.Y.U. REV. L. & SOC. CHANGE 59 (1997); Deborah A. Ellis, *Protecting "Pregnant Persons": Women's Equality and Reproductive Freedom*, 6 SETON HALL CONST. L.J. 967 (1996); Sylvia Law, *Rethinking Sex and the Constitution*, 132 U. PA. L. REV. 955 (1984).

284. See generally *Newport News Shipbuilding & Dry Dock Co. v. EEOC*, 462 U.S. 669 (1983).

285. See *1995 Proceedings of National Association of Insurance Commissioners, Consumer Participation Board of Trustees*, 1995-94 NAIC PROC. 1160, at 1165 (1996) (consumer representatives urging NAIC to develop model legislation concerning pregnancy, including preexisting condition exclusions, limits on hospital stays, anesthesia and exclusions for pregnancy and childbirth generally); Kandice Engle, *Pregnancy Discrimination in the Insurance Industry 1994*, 34 U. LOUISVILLE J. FAM. L. 177, 179 (1996).

286. See McAteer, *supra* note 113, at 1692.

287. 29 U.S.C.A. § 1181 (d)(3) (West Supp. 1998).

tion deliveries.<sup>288</sup> Moreover, many states enacted mandates providing for minimum stays or home follow-up within forty-eight hours.<sup>289</sup>

### B. *Reversible and Nonreversible Contraception*

Contraception is a high-demand health care service; approximately six in ten women (thirty-five million) between ages fifteen and forty-four either use a reversible contraceptive method,<sup>290</sup> have been sterilized, or have a partner who has been sterilized.<sup>291</sup> Twenty million women use some form of reversible contraception, "29% take oral contraceptives, 18% use condoms, 3% use the diaphragm, 3% rely on periodic abstinence, 1% have an IUD, and 5% depend on other methods."<sup>292</sup> Of unintended pregnancies, fifty-eight percent are the result of contraceptive failure and forty-eight percent are the result of failing to use any contraceptive method at all.<sup>293</sup>

Traditional indemnity insurers typically had not covered reversible contraception, although most plans covered voluntary sterilization.<sup>294</sup> Ironically, the costs associated with unwanted pregnancies are almost always covered, making the use of contraceptives cost effective

288. See 29 U.S.C.A. § 1185 (West Supp. 1998). The law was prompted by concerns over infant and maternal health and the concern that certain significant medical conditions associated with childbirth and in the newborn do not manifest prior to 48 hours. See McAteer, *supra* note 113, at 1692-93.

289. See, e.g., ALASKA STAT. § 21.42.347 (Michie 1996); ARK. CODE ANN. § 23-99-404 (Michie Supp. 1998); CAL. INS. CODE § 10123.87 (Deering 1998); D.C. CODE ANN. § 35-1102.1 (1997-98); GA. CODE ANN. § 33-34-58.1 (1997); ILL. COMP. STAT. ANN. § 5/356s (West 1998); IND. CODE § 27-8-24-5 (1998); KAN. STAT. ANN. § 40-2,160 (1997); KY. REV. STAT. ANN. § 304.17A-145 (Michie 1998); MD. CODE ANN., INS. § 15-812 (1997); MINN. STAT. § 62A.0411 (1997); MONT. CODE ANN. § 33-22-133 (1997); NEV. REV. STAT. §§ 689A.0425 (individual plans), 689B.520 (group and blanket health plans), 689C.194 (health plans for small employers) (1997); N.J. STAT. ANN. §§ 17-48-61 (hospital service corporations), 17-48A-7k (medical service corporations), 17-48E-35.9 (health service corporations), 17B-26-2.1k (health insurers), 17B-46.1k (group health and blanket insurers), 17b:27A-7.1 (individual plans) (1997); N.Y. INS. LAW §§ 3216 (individual plans), 3221 (group or blanket health plans), 4303 (non-profit medical and health and hospital service plans) (McKinney 1997); N.C. GEN. STAT. § 58-3-169 (1997); OKLA. STAT. ANN. tit. 36, § 6060.3 (1998); PA. STAT. ANN. tit. 40, § 1583 (West 1998); R.I. GEN. LAWS §§ 27-18-33.1 (insurance), 27-19-23.1 (nonprofit hospital corporations), 27-20-17.1 (nonprofit medical service corporations), 27.41-30.1 (HMOs); TX. INS. CODE ANN. § 21.53F (West 1997).

290. Reversible medical or pharmaceutical methods include, for example: "intrauterine device (IUD) insertion, diaphragm fitting, Norplant insertion, Depo Provera (DMPA) injection and oral contraception." UNEVEN & UNEQUAL, *supra* note 8, at 12.

291. See *Contraceptives*, *supra* note 272.

292. *Id.* More than 50% of pregnancies are unintended. See *id.*

293. See Law, *supra* note 69, at 364 ("[A]lmost sixty percent of the 6.3 million pregnancies that occur annually in the United States are unintended."); Alan Guttmacher Institute, *Facts In Brief, Induced Abortion* (visited July 13, 1998) <[http://www.agiusa.org/pubs/fb\\_abortion2/fb\\_abort2.html](http://www.agiusa.org/pubs/fb_abortion2/fb_abort2.html)> [hereinafter *Abortion*].

294. See UNEVEN & UNEQUAL, *supra* note 8, at 9.

and insurer decisions not to fund contraception confounding.<sup>295</sup> An important economic study of fifteen methods of contraception found all methods more effective and less costly over a five-year period than using no method of contraception at all.<sup>296</sup> It also noted that the considerable savings associated with contraceptive use directly benefited third-party payers who typically cover the costs associated with unintended pregnancies.<sup>297</sup> The study further found that contraceptives requiring physician and/or prescription services were usually more cost effective than a variety of non-medical methods, such as abstinence, withdrawal, condoms, and over-the-counter spermicides.<sup>298</sup> Thus, it appears in the third-party payer's self-interest to provide coverage for a wide range of contraceptive methods.<sup>299</sup>

### 1. Reversible Contraception

Insurance coverage for reversible contraception health service is extremely variable. "Almost half of all typical large-group plans (49%) do not routinely cover any contraceptive method at all."<sup>300</sup> Of the ninety-seven percent of plans covering prescription drugs generally, sixty-six percent exclude coverage for oral contraceptives.<sup>301</sup> In disregard of the varied health needs of women, even plans covering some

295. See Trussell, *supra* note 8, at 500; Jacqueline E. Darroch, *Cost to Employer Health Plans of Covering Contraceptives* (visited July, 13 1998) <[http://www.agi-usa.org/new/kaiser\\_0698.html](http://www.agi-usa.org/new/kaiser_0698.html)>.

296. See Trussell, *supra* note 8, at 497; Herbert B. Peterson, *A 40-Year-Old Woman Considering Contraception*, 279 JAMA 1651, 1652-53 (1998) (discussing methods of contraception and summarizing Trussell study). See generally David A. Grimes, *A 17-Year-Old Mother Seeking Contraception*, 276 JAMA 1163 (1996), available in 1996 WL 14177559 (discussing methods of contraception and summarizing Trussell study). See generally Sally Squires, *Most Pregnancies Unplanned or Unwanted, Study Says; Finding Raises Questions on the Costs and Effects of Contraception*, WASH. POST, May 9, 1995, available in 1995 WL 2092730 (citing Trussell study and concluding that covering all methods of contraception is cost effective).

297. See Trussell, *supra* note 8, at 500.

298. See *id.* The study found the lowest total cost (cost of the acquiring and using method, its side effects, and cost of unintended pregnancies resulting from failure or noncompliance) and greatest cost savings (over no method cost of \$14,663) by method over a five year period were as follows: Copper-T IUD (cost \$540/savings \$14,122), vasectomy (cost \$764/ savings \$13,899), Norplant (cost \$850/savings \$13,813), Depo-provera (cost \$1290/savings \$13,373), oral contraceptives (cost \$1784/savings \$12,879), progesterone-T IUD (cost \$2042/savings \$12,621), male condom (cost \$2424/savings \$12,239), tubal ligation (cost \$2584/savings \$12,079), withdrawal (cost \$3278/savings \$11,385), periodic abstinence (cost \$3450/savings \$11,213), diaphragm (cost \$3666/savings \$10,997), spermicide (cost \$4102/savings \$10,561), female condom (cost \$4872/savings \$9791), sponge (cost \$5700/savings \$8963), cervical cap (cost \$5730/savings \$8933). See *id.*

299. See *id.* Admittedly, the inference that insurers would enjoy a cost-savings assumes that insurance coverage for superior methods would lead to more insureds using superior methods of contraception. See *id.*

300. UNEVEN & UNEQUAL, *supra* note 8, at 12-13.

301. See UNEVEN & UNEQUAL, *supra* note 8, at 17. See also PLANNED PARENTHOOD FEDERATION OF AMERICA, FACT SHEETS: THE EQUITY PRESCRIPTION INSURANCE AND CON-

reversible contraception do not usually cover a full range of methods, thus narrowing the alternatives for their insureds.<sup>302</sup> The lack of broad coverage means some women, whose health or preferences limit choice, may not recover the cost of the method they need, even among plans that purport to provide contraception coverage.<sup>303</sup>

Cost is a key determinant in the contraceptive method chosen.<sup>304</sup> A woman's financial burden is great because, on average, women require 20.5 years of contraception care and services during their childbearing years, while they spend only 4.5 years attempting pregnancy, being pregnant, or experiencing postpartum.<sup>305</sup>

Studies indicate that providing contraception coverage would add relatively little to the average insurance premium, raising it a mere one percent.<sup>306</sup> In the public arena, the Alan Guttmacher Institute estimates that "every tax dollar spent for contraceptive services saves an average of \$3 in Medicaid costs for pregnancy-related health care and for medical care of newborns."<sup>307</sup> For a country so anxious to curb abortion demand, failing to provide broad contraception coverage makes no sense as the availability of contraception reduces the demand for abortions.<sup>308</sup>

Professor Sylvia Law argues the PDA, as now written, actually provides a mandate for contraception coverage which insurers and em-

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TRACEPTION COVERAGE ACT (visited July 22, 1998) <<http://www.plannedparenthood.org/library/BIRTHCONTROL/Equity.html>>.

302. Only 15% of large group plans covered the five methods included in the AGI study (IUD insertion, diaphragm fitting, Norplant insertion, Depo Provera injection, and oral contraception). See UNEVEN & UNEQUAL, *supra* note 8, at 12, 14. Thirty-nine percent of HMOs, on the other hand, covered all five methods. See *id.*

303. Not all methods are safe or appropriate for all women. See generally Cathryn B. Heath, *Helping Patients Choose Appropriate Contraception*, 48 AM. FAM. PHYSICIAN 1115 (1993), available in 1993 WL 12216494 (evaluating methods based on such factors as failure rate, age of patient, side effects, drug interactions, individual health risks and likelihood of compliance). Age, health, and individual risk factors make contraceptive choice imperative. See *id.* See also Peterson, *supra* note 296; Grimes, *supra* note 296.

304. See Darroch, *supra* note 295.

305. See *id.* (footnotes omitted).

306. See *id.* (reporting on Alan Guttmacher study concluding that total cost to cover would be \$17.12 for employers and \$4.28 to employees, a mean increase of 1%). See also Trussell, *supra* note 8, at 500; *Contraceptives*, *supra* note 272; Christine Woolsey, *Covering Contraceptives*, BUS. INS., Apr. 19, 1993, at 18; *New Bill to Ensure Insurers Cover Contraceptives, Birth Control Can Aid Women's Health, Lower Costs: Physician*, U.S. NEWSWIRE, available in 1998 WL 13603167 [hereinafter *New Bill*] ("[A]n insurance industry study concluded that providing comprehensive coverage for contraceptives would cost only \$16 per person per year as compared to \$5,512 for just the prenatal care and delivery of each unintended pregnancy carried to term.").

307. *Contraceptives*, *supra* note 272.

308. See Law, *supra* note 69, at 364-68 (discussing consequences of unintended pregnancies). See also PLANNED PARENTHOOD FEDERATION OF AMERICA FACT SHEETS: THE EQUITY IN PRESCRIPTION INSURANCE AND CONTRACEPTIVE COVERAGE ACT (visited July 22, 1998) <<http://www.plannedparenthood.org/library/BIRTHCONTROL/Equity.html>>.

ployers are improperly ignoring.<sup>309</sup> Professor Law points to the PDA's broad language covering "pregnancy, childbirth, or *related medical conditions*," and concludes that the prevention of pregnancy is a related medical condition.<sup>310</sup> She draws support from judicial decisions interpreting the PDA. For example, courts have brought infertility within the protection of the PDA on the premise that the law prohibits discrimination against women based upon their childbearing potential.<sup>311</sup> Using similar reasoning, courts have also prohibited discrimination against women undergoing abortion.<sup>312</sup>

The detrimental impact on women when insurers neglect sexual and reproductive health matters is most apparent in the denial of contraception coverage because the consequences of unintended pregnancy are so costly.<sup>313</sup> Congress and some state legislatures are just now considering ways to alleviate the unfair health burden caused by insurers' failure to cover reversible contraception. Recently, Maryland enacted legislation requiring insurers to provide contraceptive coverage to the same extent as other prescription drugs in its plan.<sup>314</sup> Two states have enacted mandates that require insurers to offer coverage to employer health plans as an optional rider,<sup>315</sup> and state-by-state efforts to mandate contraceptive coverage are increasing.<sup>316</sup> Furthermore, bills to mandate contraception coverage in those health care plans offering prescription drug coverage have been introduced in Congress and are pending.<sup>317</sup>

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309. See Law, *supra* note 69, at 372-86.

310. See *id.* at 381.

311. See *id.* at 380 (citing *Pacourek v. Inland Steel*, 858 F. Supp. 1393 (N.D. Ill. 1994) and *Erickson v. Board of Governors*, 911 F. Supp. 316 (N.D. Ill. 1995)).

312. See *id.* at 381 (citing 29 C.F.R. app. § 1604 (1997) and *Turic v. Holland Hospitality, Inc.*, 85 F.3d 1211 (6th Cir. 1996)).

313. See Law, *supra* note 69, at 364-68 (describing impact of unintended pregnancies on infant mortality and morbidity, financial cost, abortion, and socioeconomic status of women); Trussell, *supra* note 8.

314. See MD. CODE ANN., INS., § 15-826(b)(1) (1997 & Supp.); MD. CODE ANN. HEALTH-GEN., § 19-796(i) (1996 Repl. & Supp.) (effective October 1, 1998, Md. H.B. 457, signed into law on April 28, 1998).

315. See HAW. REV. STAT. § 431:10A-116.6 (1997) (insurers must provide, as an employer option, contraceptive services including any prescriptive drug or device approved by the FDA, to subscriber and dependents covered by the policy); VA. CODE ANN. § 38.2-3407.5:1 (Michie 1998) (insurers "shall offer and make available" coverage for any prescription drug or device approved by the FDA).

316. See Alan Guttmacher Institute, *States Acting to Expand Private Insurance Plans Contraceptive Coverage*, 8 STATE REPROD. HEALTH MONITOR (visited Mar. 1997) <<http://206.215.210.5/pubs/journals/SRHM039704.html>> (reporting on efforts in Connecticut, Illinois, California, and Hawaii); *New Bill, supra* note 306. Recently, bills requiring contraceptive coverage were introduced but have yet to succeed in the following states: Alaska, Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Missouri, New Jersey, New York, Ohio, Oregon, South Carolina, Utah, Vermont, Washington, Wisconsin. Search of Westlaw, BILLTRK database (July 7, 1998). Maryland enacted a coverage mandate on April 28, 1998. See MD. CODE ANN., HEALTH-GEN., *supra* note 314.

317. See generally Family Planning and Choice Protection Act of 1997, H.R. 2525, 105th Cong. (1997); Contraceptive Services Covered Under Certain Plans, H.R. 2174,



## 2. Sterilization

Surgical sterilization is the most common method of contraception employed in the United States, preferred by forty-two percent of couples employing a birth control method;<sup>318</sup> however, the permanency of sterilization as a birth control method makes it an unacceptable method of birth control for couples only desiring to postpone childbearing.<sup>319</sup> Forty-two percent of couples opt for sterilization; of those, females undergo tubal ligation 29.5% of the time, while men undergo vasectomies 12.6% of the time.<sup>320</sup> Both vasectomy and tubal ligation are generally covered equally under insurance policies. Coverage is far more common for this permanent method of contraception than for reversible methods of contraception,<sup>321</sup> despite the fact

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105th Cong. (1997); Coverage of Contraceptives and Contraceptive Drugs, S. 766, 105th Cong. (1997); Contraceptive Drugs and Devices Under Health Plans, S. 743, 105th Cong. (1997). See generally Government Press Releases, *Snowe Announces Senate Hearing to Address Inequities Between Men & Women in Prescription Coverage*, July 1, 1998, available in 1998 WL 7325045; *House Panel Approves Federal Insurance Coverage for Contraceptives*, ASSOCIATED PRESS POL. SERV., June 19, 1998, available in 1998 WL 7424352; Deborah Barfield, *Washington Briefing*, NEWSDAY, June 28, 1998, available in 1998 WL 2675768.

318. See *Contraceptives*, *supra* note 272. Law speculates that the preference for irreversible sterilization may be an artifact of insurance coverage, since more plans cover sterilization than reversible contraception. See Law, *supra* note 69, at 368-69.

319. See Law, *supra* note 69, at 369 & n.29 ("Many women, especially younger women, who are sterilized come to regret their decision."). Moreover, tubal ligation is not completely reliable and poses a risk for life-threatening ectopic (tubal) pregnancies. See Peterson, et al., *The Risk of Ectopic Pregnancy After Tubal Sterilization*, 336 NEW ENG. J. MED. 762, 762 (1997).

320. See *Contraceptives*, *supra* note 272.

321. Over 85% of all plan types cover both vasectomies and tubal ligation. See UNEVEN & UNEQUAL, *supra* note 8, at 17-19.

Coverage was not always the norm. The poignant case of *Price v. State Capital Life Ins. Co.*, 134 S.E.2d 171 (N.C. 1964), is illustrative. There, the insured husband sought coverage for his spouse's tubal ligation. See *id.* at 171. At issue was whether the tubal ligation surgery was "as a result of accidental bodily injuries or sickness." *Id.* at 172. No one disputed that another pregnancy would have dire consequences:

He and his wife have four children between the ages of two and thirteen years. Mrs. Price became increasingly depressed and disturbed emotionally during each pregnancy after her first. During her fourth, she was emotionally unstable throughout the entire pregnancy. She wept continuously, required drugs in order to sleep or eat, and remained in bed for most of the nine months. She narrowly escaped a complete nervous breakdown. Mrs. Price had twice been in a sanitarium for tuberculosis, the last time being four or five months after the birth of her first child.

*Id.* at 172. Her physician testified that she suffered postpartum psychosis and severe depression and that there was a danger another pregnancy would activate her arrested tuberculosis. See *id.* The court concluded that a tubal ligation to prevent potential disease was not covered (because it was preventative) but remanded for trial on the grounds that the tubal ligation may have been needed to treat her mental condition. See *id.* at 173. Cf. *Reserve Life Ins. Co. v. Whitten*, 88 So. 2d 573 (Ala. Ct. App. 1956) (tubal ligation performed following serious hemorrhaging during past pregnancies was preventative and no "existing illness" necessitated surgery).

that reversible methods and sterilization serve populations with very different reproductive needs.<sup>322</sup>

Although insurers favor coverage for surgical sterilization as a contraceptive method over reversible methods, insurers widely refuse to cover surgical reversal of elective sterilization for couples regretting their previous decision.<sup>323</sup>

Insurance companies are singularly unsympathetic to insureds who change their minds, regardless of how compelling the story.<sup>324</sup> The case of Mae Janell Shelton highlights the issue.<sup>325</sup> Mae Shelton and her first husband suffered incompatibility of Rh factor in their blood.<sup>326</sup> Following the birth of her first child, doctors advised that the incompatibility of the blood would result in the fatality of any later-conceived fetus, and she should undergo a tubal ligation to avoid any future pregnancies.<sup>327</sup> Sixteen years later, Mae entered a second marriage to a man with whom Rh incompatibility was not a factor.<sup>328</sup> The health insurance policy in question covered "necessary care and treatment of an injury or sickness."<sup>329</sup> Applying general insurance concepts of moral hazard,<sup>330</sup> the court concluded that the initial elective surgery and its voluntary reversal constituted a moral hazard for which there should be no insurance coverage.<sup>331</sup> A sharp dissent argued that Rh incompatibility was an ailment and the original decision to undergo tubal ligation merely "trade[d] one illness [Rh incompatibility] for another [infertility]."<sup>332</sup>

To argue that surgery to avoid complications from her Rh negative factor was elective is preposterous. To argue further that the inability to produce healthy, live born children does not somehow

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322. Moreover, some will eventually regret the sterilization decision. See Lynne S. Wilcox, et al., *Risk Factors for Regret After Tubal Sterilization: 5 Years of Follow-Up In A Prospective Study*, 55 FERTILITY & STERILITY 927, 932 (1991) (reporting on findings, including that young age was the strongest predictor of regret).

323. See *id.*

324. See *Reuss v. Time Ins. Co.*, 340 S.E.2d 625, 627 (Ga. Ct. App. 1986) (denying coverage to reverse vasectomy as neither an "injury or sickness" nor a "customary and necessary" charge related to covered vasectomies); *Marsh v. Reserve Life Ins. Co.*, 516 So. 2d 1311, 1315 (La. Ct. App. 1987) (reversal of tubal ligation was not treatment of an sickness and was specifically excluded as a procedure to reverse elective sterilization procedure); *Connecticut Gen. Life Ins. Co. v. Shelton*, 611 S.W.2d 928, 931-32 (Tex. App. 1981) (reversal of prior elective tubal ligation was not treatment for a sickness under terms of policy).

325. See *Shelton*, 611 S.W.2d at 928-30.

326. See *id.* at 929.

327. See *id.* The first child of Rh incompatible couples usually does not present difficulties because the mother has not yet produced antibodies to the blood of the fetus. See *id.* at 932 (Spurlock, J., dissenting).

328. See *id.* at 929. She was also advised that medical advances could restore her fallopian tubes. See *id.*

329. *Id.* at 920-30.

330. See *supra* notes 39-52 and accompanying text.

331. See *Shelton*, 611 S.W.2d at 932.

332. *Id.* at 933 (Spurlock, J., dissenting).

demonstrate a serious impairment in a female body borders on the far reaches of common sense. A primary ability of a healthy, normally functioning female is the ability to successfully bear children.<sup>333</sup>

However, as the majority held, the voluntary nature of the conduct involved constituted a moral hazard that would not be insured under general principles of insurance law without an express inclusion by the insurer.<sup>334</sup>

Couples regretting sterilization decisions find little sympathy among insurers due to the elective nature of both the decision to undergo sterilization and the decision to reverse sterilization. Curiously, while both sterilization and its reversal are regarded as elective, insurers voluntarily cover sterilization,<sup>335</sup> presumably because sterilization yields a cost benefit to the insurer.

### C. *Abortion*

Over half of all pregnancies among American women are unintended, and one-half of those unintended pregnancies are terminated by surgical abortion;<sup>336</sup> three percent of American women of reproductive age undergo abortion in a given year.<sup>337</sup> An estimated forty-three percent of women will have an abortion by the end of their reproductive years.<sup>338</sup> Most surgical abortions are performed in the first trimester when cost and safety are most favorable.<sup>339</sup> The death rate for surgical abortions is 0.2 deaths per 100,000 procedures at or before the eighth week, increasing to two per 100,000 at thirteen to fifteen weeks.<sup>340</sup>

Curiously, the presence of private or public funding has little impact on abortion decisions,<sup>341</sup> diminishing a moral hazard argument against coverage. However, the lack of insurance or public funding for abortion may have detrimental health and economic conse-

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333. *See id.*

334. *See id.* at 931 (noting also that pregnancy and childbirth are moral hazards covered only if expressly included in the insurance policy).

335. *See generally supra* note 321 and accompanying text.

336. *See Abortion, supra* note 293. Currently, RU 486, a medical (not surgical) abortion alternative has not been approved in the United States. *See Michele Lynn Lakomy, A Meaningful Choice: Two FDA Approved Drugs Are Combined to Perform Medical Abortions*, 18 *WOMEN'S RTS. L. REP.* 49, 49-50 (1996). However, a legal medical alternative involving the off-label use of two FDA approved drugs is now available. *See id.*

337. *See Abortion, supra* note 293.

338. *See id.*

339. *See id.* *See also* Lakomy, *supra* note 336, at 52-53.

340. *See* Lakomy, *supra* note 336, at 54.

341. *See* Susan Randall, *Health Care Reform and Abortion*, 9 *BERKELEY WOMEN'S L.J.* 58, 66 (1994); Millsap, *supra* note 71, at 55.

quences as a lack of financial resources may lead to dangerous delays in securing an abortion.<sup>342</sup>

Approximately two-thirds of all types of insurance plans routinely cover induced abortions.<sup>343</sup> An estimated twenty percent of the remaining plans cover abortions in some restricted fashion, while about ten percent exclude abortion procedures entirely.<sup>344</sup> Insurer decisions to cover abortions are voluntary, as the PDA expressly provides that declining coverage for abortion is not discriminatory.<sup>345</sup>

Abortion is a politically-charged issue, and therefore, state and federal mandates to increase coverage for abortion are extremely unlikely. Instead, legislative action and public attitudes pose a threat to abortion coverage at this time.<sup>346</sup> Unlike other health coverage mandates, government mandates in the abortion arena usually limit rather than expand elective abortion coverage. For example, a few states prohibit inclusion of abortion coverage as part of the standard insurance policy and allow coverage for elective abortions only by way of an optional rider.<sup>347</sup> Pennsylvania requires insurers to provide a choice as to coverage by offering policies both with and without express abortion coverage.<sup>348</sup> These statutes allow employers purchasing insurance for employees substantial influence over the reproductive health

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342. See Randall, *supra* note 341, at 69 (citing Stanley K. Henshaw & Lynn S. Wallisch, *The Medicaid Cutoff and Abortion Services for the Poor*, 16 FAM. PLAN. PERSP. 170, 178-79 (1984)).

343. See UNEVEN & UNEQUAL, *supra* note 8, at 19. The breakdown by type of plan is: 66% of large group fee-for-service plans, 67% of PPOs, 83% of POS networks and 70% of HMOs. See *id.* See also Randall, *supra* note 341, at 63.

344. See UNEVEN & UNEQUAL, *supra* note 8, at 19.

345. See 42 U.S.C. § 2000e(k) (1994).

346. See Randall, *supra* note 341, at 63-64. Public controversy and criticism also threatens the availability of abortion services; fewer physicians are now trained to perform abortion and there has been a decline in the number of abortion providers over time. See Lakomy, *supra* note 336, at 53, 64. Only approximately 34% of gynecologists perform surgical abortions. See *id.* at 53. See also Ann MacLean Massie, *So-Called "Partial-Birth Abortion" Bans: Bad Medicine? Maybe. Bad Law? Definitely!*, 59 U. PITT. L. REV. 301, 308-10 (1998) (describing and criticizing federal and state efforts to ban late term, dilation and extraction abortion method).

347. See Randall, *supra* note 341, at 63-64 (noting that six states currently limit coverage except by optional rider with additional premium or some other restriction). See, e.g., IDAHO CODE § 41-2210A (1997); KY. REV. STAT. ANN. § 304.5-160 (1997); MO. REV. STAT. § 376a.805(1) (1998); N.D. CENT. CODE § 14-02.3-03 (1997); R.I. GEN. LAWS § 27-18-28 (1997) (reenacted following determination of unconstitutionality in *Nat'l Educ. Ass'n v. Garrahy*, 598 F. Supp. 1374 (D.R.I. 1984), *aff'd* 779 F.2d 790 (1st Cir. 1986)). See *Coe v. Melahn*, 958 F.2d 223, 225-26 (8th Cir. 1992) (optional rider provision in Missouri statute does not impose an undue burden on abortion decision but whether it is rationally related to a legitimate government purpose remains a question of fact).

348. See 18 PA. CONS. STAT. ANN. § 3215(e) (West 1997).

decisions of their employees.<sup>349</sup> Other states limit abortion coverage for public employees under their employer plans.<sup>350</sup>

If health reform occurs at the federal level, the relatively generous coverage by private insurers may be threatened by federal interference.<sup>351</sup> Currently, federally-paid insurance plans for public employees and dependents do not cover abortion except in instances to save the life of the mother, or when pregnancy is the result of rape or incest.<sup>352</sup>

Federal opposition to public funding for abortion creates a vast difference between private insurance and Medicaid coverage for abortions. Under the Hyde Amendment, federal money may not be spent on abortion except in very limited circumstances.<sup>353</sup> Although state Medicaid programs may fund abortion using nonfederal money, the majority of states do not provide state assistance.<sup>354</sup>

349. See Havighurst, *supra* note 10, at 1767 & n.27 (noting that employers are not always looking out for employees when negotiating the insurance contract).

350. See Randall, *supra* note 341, at 64. An Alan Guttmacher survey in May 1998, reports that nine states preclude insurance coverage for public employees (Colorado, Illinois, Kansas, Michigan, Nebraska, North Dakota, Pennsylvania, Rhode Island, and Virginia). See AGI, THE STATUS OF MAJOR ABORTION-RELATED LAWS IN THE STATES (visited July 20, 1998) <[http://www.agi-usa.org/pubs/abort\\_law.status.html](http://www.agi-usa.org/pubs/abort_law.status.html)>.

351. See Randall, *supra* note 341, at 67.

352. See Treasury, Postal Service, and General Government Appropriations Act for Fiscal Year 1998, PUB. L. NO. 105-61, § 513, 111 STAT. 1272, 1305 (1997). Like the Hyde Amendment, the prohibition is added to an appropriation bill and is not permanent law; consequently the provision may vary from year to year. See Randall, *supra* note 341, at 64 & n.29 (noting that appropriations in fiscal year 1994 did not contain a rape and incest provision). CHAMPUS prohibits abortion coverage except to save the life of the mother. See 32 C.F.R. § 199.4(e)(2) (1998).

353. Under the Hyde Amendment, a section reenacted each year within the Department of Health and Human Services Appropriations Act, federal money provided to fund state Medicaid programs may not be used to fund abortion services except in limited circumstances. See, e.g., Departments of Labor, Health and Human Services, Education and Related Agencies Appropriations Act, 1998, PUB. L. NO. 105-78, § 509, 111 STAT. 1467, 1516 (1997). In fiscal year 1998, public money could not be used to fund abortion except in the case of "rape or incest" or "where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed." *Id.* at § 510 (a)(1)-(2). The Hyde Amendment differs from year-to-year, in previous years abortion coverage has been limited to life-saving necessity. See Dalton v. Little Rock Family Planning Servs., 116 S. Ct. 1063, 1065 (1996) ("The Hyde Amendment is not permanent legislation" and different versions of it have been enacted from time to time); Randall, *supra* note 341, at 65 & n.44 (discussing various Hyde Amendments).

354. States may voluntarily provide coverage using nonfederal funds. See PUB. L. NO. 105-78 § 510 (b), *supra* note 353. According to the Alan Guttmacher Institute, only seventeen states fund some abortion services with state funds. See *Status of Major Abortion-Related Laws in the States*, *supra* note 350 (Alaska, California, Connecticut, Hawaii, Idaho, Illinois, Maryland, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, New York, Oregon, Vermont, Washington, and West Virginia). See generally PLANNED PARENTHOOD FEDERATION FACT SHEETS: STATE LAWS RESTRICTING ACCESS TO

## V. COVERAGE FOR INFERTILITY

When a couple is unable to conceive a child, the psychological pain is significant, and the impact of the diagnosis often pervades daily life, work, marriage, and relationships with others.<sup>355</sup> Infertility affects fifteen percent of couples over the reproductive lifetime of the female partner.<sup>356</sup> Male factors contribute at least forty percent to fifty percent of the time.<sup>357</sup> At any given time, one to 1.5% of women of reproductive age seek infertility care.<sup>358</sup>

Insurers often cover some of the less costly diagnostic tests and treatments, while denying coverage for more expensive assisted reproductive technologies through express exclusions.<sup>359</sup> Expenses related to diagnosing and treating infertility vary because of the wide range of causes.<sup>360</sup> Diagnosis is complex, and the tests and procedures needed

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ABORTION 25 YEARS AFTER ROE V. WADE (visited July 22, 1998) <<http://www.plannedparenthood.org/library/ABORTION/StateLaws.html>>. See also Dalton, 116 S. Ct. at 1064-65 (1996).

355. See Keith Alan Byers, *Infertility and In Vitro Fertilization*, 18 J. LEGAL MED. 265, 270-71 (1997) (discussing psychological impact); Cole, *supra* note 113, at 732-33 (discussing "devastating effect"); Rhonda S. Tishcler, Comment, *Infertility: A Forgotten Disability*, 41 WAYNE L. REV. 249, 251-52 (1994) (discussing "terrible emotional and physical toll"); Linda J. Lacey, *O Wind, Remind Him That I Have No Child: Infertility and Feminist Jurisprudence*, 5 MICH. J. GENDER & L. 163, 167-68 (1998) (describing desire to have children).

356. See Arnold Cohen, *Managed Health Care's Approach to Infertility*, 9 INFERTILITY AND REPROD. MED. CLINICS OF N. AM. 21, 21 (1998).

357. See Manoj Monga & Wayne J.G. Hellstrom, *Many Paths to Medical Therapy for Male Infertility*, CONTEMP. UROLOGY, Sept. 1996, at 23, 47 (reviewing studies of hormonal and nonhormonal treatments of male infertility and noting that no medication has been specifically approved by the Food and Drug Administration for treatment of male infertility). Surgical treatment for certain male conditions may be appropriate. See Larry Lipshultz, et al., *Reproductive Microsurgery: Alternatives and Obstacles*, CONTEMP. UROLOGY, June 1996, at 15, 15.

358. See Cohen, *supra* note 356, at 21.

359. Coverage for infertility varies and depends on the therapeutic service sought.

Sixty-one percent of large-group plans, 57% of PPOs, 66% of POS networks and 91% of HMOs routinely cover semen analysis in their typical policy. Endometrial biopsy is covered by 76% of large-group plans, 73% of PPOs, 78% of POS networks and 90% of HMOs.

Clomid, a prescription drug widely used to treat infertility in women, is routinely covered by 40% of large-group plans and PPOs and 48% of POS networks and 67% of HMOs . . . .

In vitro fertilization (IVF) is rarely covered, regardless of the type of plan. IVF is routinely covered by 14% of large-group plans, 16% of PPOs and 17% of POS networks and HMOs.

UNEVEN & UNEQUAL, *supra* note 8, at 22, 26. *But cf.* Christine Gorman, *Playing the HMO Game*, TIME, July 13, 1998, at 26 (reporting that an increasing number of large employer-sponsored HMO plans are covering in vitro fertilization).

360. See Edward Zbella, *The Physician's View of Managed Care in Reproductive Medicine*, 9 INFERTILITY AND REPROD. MED. CLINICS OF N. AM. 1, 8 (1998); O'Rourke, *supra* note 113, at 347-53; OFFICE OF TECH. ASSESSMENT, U.S. CONGRESS, OTA-BA-358 INFERTILITY: MED. AND SOC. CHOICES 139-44 (1988) [hereinafter OTA].

to confirm infertility can be expensive.<sup>361</sup> Once diagnosed, numerous therapies may be attempted to treat infertility, including hormonal therapy, drug therapy, and surgery. Coverage for these treatments is variable, with insurers picking up approximately seventy percent of the costs other than the assisted reproductive technologies.<sup>362</sup>

When the underlying infertility cannot be treated, patients may desire assisted reproductive technologies to aid in fertilization and conception.<sup>363</sup> These therapies<sup>364</sup> are costly, but only three percent of

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361. See Zbella, *supra* note 360, at 8 (describing coverage for diagnostic procedures under AETNA). The infertility workup may include: confirmation of inability to conceive despite six months of unprotected sex, physical exam, evaluation of ovulation, semen analysis, endocrinological examination, endometrial biopsies at timed intervals, hysterosalpingography, laparoscopy, hysteroscopy, and ultrasonography. See O'Rourke, *supra* note 113, at 350-51 (describing varied causes of infertility); Cole, *supra* note 113, at 734-35 ("average cost per couple for infertility treatment, including IVF, is actually estimated to be very low, at \$200 per couple").

In 1988, the Office of Technology Assessment, undertook a comprehensive examination of infertility, including a survey of costs for various diagnostic procedures and treatments. See OTA, *supra* note 360, at 139-62.

362. The Office of Technology Assessment found that non-IVF insurance coverage approximated 70%, individuals paid 22%, and other sources covered the remainder. See OTA, *supra* note 360, at 148-49. However, "[t]he majority of health insurance plans and health maintenance organizations exclude specific coverage for IVF." *Id.* at 153. See also Solomon Leftin, *Insurance Coverage of Infertility Treatments and Procedures*, 19 COLO. LAW. 663, 663-64 (1990) (noting that initial diagnostic testing generally costs about \$5,000); Tischler, *supra* note 355, at 254-55.

However, some insurers take the position that infertility treatment is not covered because it is not medically necessary. For example, in *Thomas v. Truck Drivers and Helpers Local No. 335, Health and Welfare Fund/Pension Fund*, 771 F. Supp. 714, 714 (D. Md. 1991), the insured sought coverage for a bilateral vasopidymostomy to clear an obstruction of the epididymis that prevented his fertility. The plan provided coverage for specific operations and also covered other medical expenses in its discretion that were not expressly excluded. See *id.* at 715. The plan excluded "[e]xpenses not connected with the care and treatment of an actual injury or sickness." *Id.* The insurer contended the surgery was not medically necessary because the insured sought the treatment to impregnate his wife. See *id.* The court found the plan's determination not to cover the treatment was not an abuse of its reserved discretion. See *id.* at 716-17.

Aetna reports that the average infertile patient care costs are between \$1,000-\$4355 without assisted reproductive technologies. See Cohen, *supra* note 356, at 22. In Massachusetts, where infertility care is mandated, the cost, with assisted reproductive technologies for a successful pregnancy is \$39,375, other estimates range from \$60,000 to \$800,000 per successful pregnancy. See *id.* (footnotes omitted). See also Meena Lal, Comment, *The Role of the Federal Government in Assisted Reproductive Technologies*, 13 SANTA CLARA COMPUTER & HIGH TECH. L.J. 517, 530-31 (1997) (\$8-12,000 per IVF cycle).

363. See O'Rourke, *supra* note 113, at 353.

364. O'Rourke identifies and describes the following assisted reproductive technology therapies: artificial insemination by husband, artificial insemination by donor, in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), Pro-Nuclear Stage Transfer (PROST), zygote intrafallopian transfer (ZIFT), tubal embryo transfer (TET), and natural cycle ovum retrieval intravaginal fertilization (NORIF). See O'Rourke, *supra* note 113, *passim*.

Americans pursuing infertility treatment actually seek the more costly assisted reproductive technologies.<sup>365</sup> Importantly, the relatively low demand for assisted reproductive technologies suggests providing coverage for infertility would not adversely affect insurance premiums.<sup>366</sup>

State legislatures began to mandate coverage for infertility services in the 1980s, as infertile couples attempted to overcome the express exclusions springing up in health insurance policies.<sup>367</sup> Twelve states either mandate coverage or mandate that insurers offer coverage for assisted reproductive technologies.<sup>368</sup>

The methods insurers use to avoid coverage under the insurance contract include express exclusions, and arguments that assisted reproductive technologies are not medically necessary, are experimental, or do not treat a disease.<sup>369</sup> Insurers are adverse to covering

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365. See Neumann, *supra* note 52, at 1220-21. In vitro costs approximately \$10,500 per cycle. See *id.* at 1221. When the success rate (about 15% on first attempt) is considered, the cost of per in vitro delivery is estimated at between \$66,667 (on first cycle) to \$114,286 (on sixth cycle). See *id.* at 1222.

366. See Cole, *supra* note 113, at 734-36; OTA, *supra* note 360, at 155. Neumann points out:

It is important to note that even with large utilization increases [as a result of coverage], health insurance premiums would likely not increase very much with coverage, because the fraction of couples in the population who use IVF services is small. Only about 3 percent (or fewer than 50,000) of Americans who seek treatment for infertility each year receive IVF. Collins . . . estimated that even if utilization rose 300 percent as a result of adding IVF services to a typical employer health plan, average premiums per employee would only rise about \$9 per year. Another group previously estimated that in 1990, IVF would have added under a dollar to annual premiums, as opposed to \$7 for chiropractic services and \$26 for alcoholic and psychiatric services.

Neumann, *supra* note 52, at 1220-21 (references omitted). Others report that coverage experiences have ranged from \$.60 per person per month to \$1.70. See Tischler, *supra* note 355, at 255-56; OTA reported that Delaware Blue Cross/Blue Shield's voluntary coverage of IVF and other infertility services resulted in a \$.60 cost per person per month and in Maryland the cost amounted to \$1.06 per household per month. See OTA, *supra* note 360, at 155.

367. Neumann notes a slowing in the trend of the 1980s among states to mandate coverage. See Neumann, *supra* note 52, at 1226.

368. See AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE, STATE INFERTILITY INSURANCE LAWS (visited June 19, 1998) <<http://www.asrm.org/patient/insur.html>>; Neumann, *supra* note 52, at 1218 (discussing state laws); Cole, *supra* note 113, at 724-27 (discussing state laws); Tischler, *supra* note 355, at 258-62 (discussing state laws); Note, *In Vitro Fertilization: Insurance and Consumer Protection*, 109 HARVARD L. REV. 2092, 2097-99 (1996).

369. See Cole, *supra* note 113, at 719-723 (discussing case law); Bonny Gilbert, *Infertility and the ADA: Health Insurance Coverage for Infertility Treatment*, 63 DEF. COUNS. J. 42, 44-46 (1996) (discussing case law).

For notable cases covering infertility treatment or finding sufficient dispute to send for trial, see *Egert v. Connecticut General Life Insurance Company*, 900 F.2d 1032, 1036-38 (7th Cir. 1990) (infertility is an illness under the policy and in vitro is treatment even though it will not cure the underlying disease); *Reilly v. Blue Cross and Blue Shield United of Wisconsin*, 846 F.2d 416, 423-24 (7th Cir.) (reversing summary judgment for insurer; material question of fact whether insurer acted arbitrarily in deny-



assisted reproductive technologies in part because they view such treatment as a moral hazard: First, the decision to have a child is a personal choice within the control of the individual; second, insurers view unrealistically desperate infertile couples as driven to overuse the assisted reproductive technologies despite a relatively low success rate associated with the treatment.<sup>370</sup>

## VI. CONCLUSION: IT IS TIME TO REWRITE THE INSURANCE CONTRACT

Insurance coverage for sexual and reproductive health is both piecemeal and irrational. The insurer preference to cover disease and surgery over health maintenance and prevention means that the typical health insurance contract is inadequate to meet our sexual and reproductive health needs. The pervasive reliance on express exclusions to avoid covering matters of sexual and reproductive health suggests that insurers do not regard sexual and reproductive health as basic health care. However, both consumer studies and the evidence of high demand for sexual and reproductive health care services suggest that consumers need and want coverage for their sexual and reproductive health needs.<sup>371</sup> Demanding that insurers cover sexual and reproductive health care is not demanding "cadillac" coverage; rather, sexual and reproductive health care should be fundamental to a basic health insurance contract.<sup>372</sup>

Because insurers are out-of-step with consumers, consumers are turning to the legislative process to assist in negotiating better insurance contracts. However, state and federal mandates offer a poor solution to changing the insurance coverage landscape for several reasons. First, state mandates do not impact a large segment of health plans such as those of federally-funded plans for government workers or Medicare recipients, as well as ERISA self-insured plans. Second, as the abortion debate demonstrates, both federal and state mandates may target particular procedures for exclusion, thus making the private insurance contract subject to political winds. State and federal

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ing benefits because it considered in vitro experimental), *cert. denied*, 488 U.S. 856 (1988); *Witcraft v. Sunstrand Health and Disability Group Benefit Plan*, 420 N.W.2d 785, 788-90 (Iowa 1988) (infertility is a disease and covering artificial insemination where infertility is due to irregular ovulation and low sperm count); *Ralston v. Connecticut General Life Ins. Co.*, 617 So. 2d 1379, 1381-82 (La. Ct. App.), *rev'd and remanded* 625 So. 2d 156 (La. 1993) (reversing judgment in favor of insureds and remanding for trial to determine whether in vitro was treatment for a sickness and was medically necessary). For a notable case denying coverage, see *Kinzie v. Physician's Liability Insurance Company*, 750 P.2d 1140, 1142-43 (Okla. 1987) (in vitro was not medically necessary because in vitro did not treat the infertile condition).

370. See Mueller, *supra* note 39, at 114.

371. See UNEVEN & UNEQUAL, *supra* note 8, at 25. See also *supra* note 60.

372. See Ira Mark Ellman & Mark A. Hall, *Redefining the Terms of Health Insurance to Accommodate Varying Consumer Risk Preferences*, 20 AM. J.L. & MED. 187, 188 (1994) (proposing "cadillac" and "chevrolet" health plans, not based on exclusions, but on budgeted risk preferences).

mandates are a double-edged sword when it comes to seeking sexual and reproductive health coverage. Third, because employers, not individuals, negotiate most insurance contracts, mandates that merely require insurers to offer coverage to employers give insureds limited choice, at best. Finally, mandates do not necessarily reflect rational medical priorities, but rather the popular disease or treatment of the day.<sup>373</sup>

There are a variety of explanations for insurer resistance to reproductive and sexual health care coverage. In some cases, as in coverage for Viagra or contraception, insurers deny coverage as they fear the excessive and uncontrollable demand. Indeed, because of our sexual nature, treatment for sexual and reproductive health services are often highly demanded; however, the need is basic and important, and does not justify insurers' evasion of coverage. If, as in the case of Viagra, insurers fear the vagaries of diagnosis and abuse, then the solution should be developing external controls and well-articulated standards rather than denying coverage altogether for legitimate claims.

Insurers correctly recognize that sexual and reproductive activity is voluntary, and insureds possess an ability to create claims. Human activity is largely voluntary, yet insurers nevertheless cover the health risks associated with nonsexual human activity in general. Furthermore, insurers probably overestimate the effect of insurance on sexual and reproductive health care choices because significant external controls, such as the pain and discomfort of treatment, nonmedical costs, and favorable and unfavorable social and emotional consequences drive decision-making. Moreover, the fear of overutilization does not justify excluding coverage for necessary, basic sexual and reproductive health care. Instead, insurers have a responsibility to participate in developing effective controls such as standards of care, diagnostic criteria, and appropriate patient management.

At the heart of the patchwork of coverage and exclusions for matters of sexual and reproductive health, remains the fact that insurance coverage is rooted in value-laden principles viewing sexuality as repugnant and immoral. Insurers should shed out-dated values, accept our sexual nature, and provide Americans with basic sexual and reproductive health care. Insurers must acknowledge that insureds are not

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373. See JERRY, *supra* note 129, at 437-40 (discussing impact of state mandates and noting that they often reflect political power and influence rather than sound health policy); Dan Wascoe, *Legislators Often Answer Call To Mandate Health Care*, STAR-TRIB. (Minneapolis-St. Paul), Feb. 18, 1996, at B1 (noting the increasing popularity of state mandates, commenting that Minnesota has 30 state mandates including among others, coverage of hair pieces following cancer treatments, removal of birthmarks, bone marrow transplants for breast cancer); Cole, *supra* note 113, at 734 (noting wide range of insurance mandates in California); O'Rourke, *supra* note 113, at 386 & n.414.

asexual, and consumers expect coverage for this important aspect of their overall health.

